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The Work and Health of *Dais*: The Effect of Authoritative Perception on Indigenous Midwives of Gujarat, India

by

Subadhra Devi Rai ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Doctor of Philosophy

Medical Sciences - Public Health Sciences

Edmonton, Alberta

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Abstract

The Gujarat government and SEWA (Self-Employed Women's Association) understand that grinding poverty is a cause of ill health. Women need secure income and work to remain healthy. The multiple economic niches created by women in the informal sector are key to their survival. They are a source of income in an environment of high under- and unemployment. That is why SEWA supports *Dai*s' (indigenous midwives') work. SEWA wants indigenous midwifery to be considered as an independent, stand-alone profession. The goal is to build *Dai*s' economic and social capacity through skills upgrading and credentialisation.

The Gujarat government's development schemes exclude *Dai*s. Its goal to phase *Dai*s out without economic alternatives is inconsistent with its objectives to address gender bias and poverty. By identifying *Dai*s' work as community participation, the important health and economic contributions of *Dai*s are devalued.

The concept of authoritative perception provides insights into how the broad interpretations of *Health for All* and *Reproductive and Child Health* frameworks have provided justification for the continuation of previous programmes such as the GOI's *Community Needs Assessment Approach* framework. The focus is on population control and not the socioeconomic issues of *Dai*s. Power is central to ensure that the authoritative perception is presented as correct and therefore accepted.

Work and skill are socially and politically defined and subject to change. Labels such as informal/formal, paid/unpaid, and skilled/unskilled shift to meet the needs of the overall health and economic systems. *Dai*s are beginning to perceive this link between level of income and the authoritative perceptions of their work. It is not enough to have work. The type of work, level of remuneration and how it is perceived are all important factors that affect the value of work.

The findings in this study underscore the importance of contextualising health frameworks and initiatives within social environment.

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The end of my doctoral journey and the beginning of a new one is expressed in the following prayer of Gayatri Mantr:

Aum bhur bhuvah svahah
Tat savitur varenyam
Bhargo Devasya dheemahi
Dheeyo yonah prachodayaat

Aum, O Lord! You are all pervading Source of Light,
Sustainer, Protector and Bestower of Happiness, Creator of Universe,
Thou art most luminous, pure and adorable,
We meditate on thee,
May thou inspire and guide our intellect in the right direction.

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List of Acronyms

AMC	Ahmedabad Municipal Corporation
ANM	Auxiliary Nurse Midwife
BEE	Block Extension Educator
CDHO	Chief District Health Officer
CHC	Community Health Centre
CHETNA	Centre for Health Education, Training and Nutrition Awareness
CHW	Community Health Worker (SEWA)
CNA	Community Needs Assessment Approach
CSSM	Child Survival and Safe Motherhood
DDK	*Dai* Delivery Kit (or Disposable Delivery Kit or *Mamta Kit*).
DHO	District Health Officer (usually a medical doctor)
EOC	Emergency Obstetric Care
EPI	Expanded Programmed of Immunisation
FHW	Female Health Worker
FHS	Female Health Supervisor
FP	Family Planning
FPU	Family Planning Units
GOG	Government of Gujarat
GOI	Government of India
HFA	Health for All (also known as the Alma-Ata Declaration to promote primary health care)
ICDS	Integrated Child Development Services
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication (another name for BEE)
IMR	Infant Mortality Rate
LEB	Life Expectancy at Birth
MO	Medical Officer (medical doctor)
MOHFW	Ministry of Health and Family Welfare
MMR	Maternal Mortality Rate
MPW	Male Multi-Purpose Worker (or Male Health Worker)
MTP	Medical Termination of Pregnancy
NFHS	National Family Health Survey
PHC	Primary Health Centre
PPU	Post Partum Units
RCH	Reproductive and Child Health
SEH	Socioeconomic determinants of health
SEWA	Self-Employed Women's Association
SICI	Shastri Indo-Canadian Institute
SIHFW	State Institute of Health and Family Welfare
UIP	Universal Immunisation Programme
UEE	Universal Elementary Education
UPE	Universal Primary Education
VDG	Village Development Group

Gujarati Terms

Aganwadi	Child care centre. Those who work there are known as *aganwadi* workers.
Agarbatti	Incense stick
Atma	Soul
Bidi	Indigenous cigarette
Dharm	Duty or one's religion
Gerthuthi	A mixture of ghee, jaggery, and boiled water. It is the first feed given to an infant prior to breastfeeding.
Ghee	Clarified butter
Jaggery	Brown sugar made from sugar cane juice
Papad	Crackers made of lentil flour and spices
Poonya ka kaam	Good work or work of blessing
Sarpanch	Village head
Talati	Revenue collector
Utkaaro	A drink made of black pepper, jaggery, and dry ginger. This is given to the woman in labour to accelerate her labour contractions.

CHAPTER 1

INTRODUCTION

Research Context

In 'developing' nations, ensuring safe motherhood is the highest priority. Each year 600,000 women around the world die of complications related to pregnancy, of which less than 1% occur in the 'developed' countries (World Health Organisation [WHO], 1998c). The direct causes of maternal mortality are infection, obstructed labour, hypertension, haemorrhage, and unsafe abortion (WHO, 1998c). The indirect causes include poverty and inaccessible health facilities (WHO, 1998d, 2000a). In India alone about 125,000 women die each year from these pregnancy-related causes (UNICEF, 1999). The majority of women who die are young, and often the cause of their deaths is preventable (UNICEF, 1999). UNICEF noted that accurate data on India's maternal mortality are unavailable, and this in itself is a powerful commentary on the low priority placed on women's health. Statistics show that in India less than 25% of deliveries occur in institutions, and in tribal areas about 10% to 15% of women die on the way to hospitals (UNICEF, 1999).

In India, *Dai*s (indigenous midwives) conduct about 50% to 60% of the deliveries (Swaminathan, Naidu, & Krishna, 1986); whereas in Gujarat, *Dai*s handle between 40% and 95% of deliveries (Chatterjee, 1999; State Institute of Health and Family Welfare [SIHFW], 1999). The data illustrate *Dais*' important contributions to the health care system, and, in particular, they show the extent of their workload. Furthermore, the data indicate that women have access to affordable and accessible labour and delivery services and other primary health care, an expressed goal of the joint WHO/UNICEF (WHO, 1978) *Health for All* (HFA) Declaration. Interpreted another way, the statistics indicate that if *Dai*s were not present to meet the demand for delivery services, a vast majority of women would be without this obstetric care. There is increased realisation that despite the various health policies and implementations, the health care system has not met basic health needs, especially delivery services in India and in Gujarat. Both the Government of India (GOI) and international agencies, however, continue to promote the framework of HFA because they perceive it as the most cost-effective way (appropriate and accessible) to meet the health needs of the population. A recent joint statement and initiative by WHO, UNICEF, UNESCO, UNFPA, UNAIDS, and the World Bank, called *Health: A Key to Prosperity*, identified "the home as the first hospital" (WHO, 2000b). This means that the first line of treatment, prevention, rehabilitation, and health promotion has to begin at the grassroots level, the community. The idea is to equip community members with basic knowledge of primary health so that they can identify and treat illnesses and promote health.

Within this context, *Dai*s play a pivotal role in providing health care to women of urban and rural Gujarat. Previous studies done by WHO (Cabral, Kamal, Kumar, & Mehra, 1992a, 1992b, 1992c; Du Gas, Mangay-Maglacas, Pizurki, & Simons, 1979; Mangay-Maglacas & Pizurki, 1981; Mangay-Maglacas & Simons 1979; Verderese & Turnbull, 1975; Walt, 1984; WHO, 1982, 1995a, 1995b) and in India and Gujarat (SIHFW, 1983, 1992, 1995, 1999; Swaminathan et al., 1986) have concentrated on the potential benefits to the healthy delivery of mother and child when indigenous midwives receive biomedical training. None focussed on the effect of *Dai*s' work on their own health. In fact, the discussions about indigenous midwives in India and elsewhere show that they, themselves, and those around them, do not perceive midwives as formal workers, but rather as women assisting other women in the birthing process. Nevertheless, the low rate of institutional births in India indicates that *Dai*s play a key role in health care provision of women.

Defining the Problem

The purpose of this research was to explore the relationship between work and the health of the *Dai*s in Gujarat, India. This is a shift from previous literature on the impact of *Dai*s' work on their women clients and explores, instead, how *Dai*s' work affects their own health and the health of those around them. Multiple perceptions of *Dai*s' work vis-à-vis social and economic values were collated to understand how these perceptions affect their health. Perceptions are important in determining whether individuals value their work and whether they are contributing to society, thus further affecting the way they perceive themselves. In the case of the *Dai*s, how others perceive them may affect their social position and level of remuneration.

Wilkinson (1996) noted that those who have expanded social networks and social support enjoy good health. Marmot's classic longitudinal Whitehall study monitoring British civil servants over a period of 20 years (and still continuing, Whitehall Study II) showed that perceived inequality and social hierarchy do contribute to ill health (Evans, 1994). Sen (2000) observed that one of the causes of social exclusion is unemployment, and others indicate that wide income disparity in society affects social cohesion (Kawachi, Kennedy, Lochner, & Prothrow-Smith, 1997; Morris, Bernhardt, & Handcock, 1994). A study by Kuate Defo (1997) in Cameroon showed that the burden of ill health is carried disproportionately by women, who are economically disadvantaged and of low status. Furthermore, her study indicated that women who are socially disadvantaged, including those who are unemployed and live in poor neighbourhoods, experience a higher rate of morbidity. Consequently, they and their children experience a high rate of illness (Kuate Defo, 1997). Canada's National Forum on Health (1997) observed that unemployment and shrinking income are among the main stressors that caused ill-health in Canadians. The studies indicated that wide income differentials and job insecurity affect the health of the individuals and those around them. Based on these observations on the relationship between work and well-being, there are two reasons that this study on *Dai*s' work and health is critical and timely.

The first is related to the statistical proof that *Dai*s conduct a significant percentage of deliveries. Despite the evidence, *Dai*s are regarded as informal workers or helpers and not part of the workforce. The second reason is understanding the impact of doing work that is necessary but culturally unappealing: Why do women work as *Dai*s, and what are the consequences of doing this type of work on their lives? If assistance during delivery is necessary to ensure that the process of birth is uneventful, then it is important to understand why this work has low value both in monetary terms and socially. There appears to be a dissonance in perception between the actual contributions of *Dai*s and their status as workers, and the value of their work. The aim of my qualitative research is to probe deeper into why this dissonance exists.

Women's Work: A Need for Better Valuation

Understanding the parameters that define work (formal/informal, paid/unpaid) would have a profound effect on the way *Dai*s' work is evaluated economically. This is especially needed in the current environment where there is a move to institute UNFPA's 1994 *Reproductive and Child Health* (RCH) framework, which states that women's work plays a central role in their health. In view of this, both the Self-Employed Women's Association (SEWA), a women's development organisation located in Gujarat, India, and the formulators of RCH have called for a broader definition of work. This call has important ramifications on the future development of *Dais*' work. According to the *World Survey on the Role of Women in Development* (UN, 1999), women are the ones who carry out the bulk of unpaid work, and in many countries female labour is still perceived as easily attainable and available when needed and dispensable when it is not. Thus how the Gujarat government evaluates and contextualises *Dais*' work depends on (a) how it defines productive work, and (b) how it interprets the RCH framework in relation to work. The relevance of RCH to *Dais*' work becomes apparent because the success of the framework is predicated on empowering women, providing them with choices through increased access to educational and health services, promoting skill development and employment, and removing barriers that impede women's access to stable income and work (UNFPA, 1994).

The International Labour Organisation (ILO, 1996a) noted that women's contributions are underestimated because they do not have equal access to stable employment. This has led to the emergence of "ghost work," also known as invisible work in the domestic and informal sectors. The ILO predicted that if unpaid and invisible work by women were accurately accounted for, their levels of economic activity would increase by 10% to 20% and the GDP would increase by 25% to 30% worldwide. Furthermore, the ILO found that in terms of work hours per week, the greatest gap between men and women was found in Asia, where women worked on average 12 to 13 hours more than men. The ILO (1996b) noted that when the parameters of economic activity were broadened to cover the informal sector and nonmarket activities, the measured labour force activity of women in India rose from 13% to 88%. Informal work such as work in the home or subcontracted work is usually strenuous, is poorly paid, and offers few or no opportunities for training and reduced career advancements (Chandola, 1995; ILO, 1996b). Informal work usually parallels women's domestic roles and is devalued because of its feminised nature (Chandola, 1995; ILO, 1996a, 1996b; UN, 1999). For all these reasons, understanding *Dais*' work beyond the statistical data on the percentage of deliveries conducted is crucial. There needs to be a better understanding of the extent of their contributions and a more refined conceptualisation of informal work. Percentages hide the power relations that relegate

*Dai*s as informal and marginal workers. A concerted effort is being made worldwide to monitor each country's human resource development because it has emerged as the most important variable in economic growth (UN, 1999). It was found that women significantly increased their participation in the labour force, entering the informal employment under insecure and worsening economic conditions (UN, 1999). Women worked longer and harder, both inside and outside the households, and as a result, their welfare suffered because the increased burden of work exerted a heavy toll on their physical and mental health (UN, 1999).

Community Participation and Work

There is also a need to examine whether community participation as promoted by HFA has led to increased informalisation and invisibility of *Dai*s' work. This is the second reason for this study. Although the concept of community participation is attractive and connotes increased involvement at the grassroots, its impact on *Dai*s' work is unknown. Community participation covers a wide range of activities, and it is unclear where *Dai*s' work fits into this continuum. Exploring this fit is crucial because it will increase our understanding of how *Dai*s' work is valued socially and economically. In addition, it would inform policymakers of the involvement of other individuals in facilitating *Dai*s' work and the hidden costs incurred by community members. Indeed, community participation masks the political nature of work and ignores the social and economic structures that marginalise individuals. Navarro (1984) noted that the apolitical nature of community participation promoted by WHO's HFA disregards the vested interests of power holders and does not challenge or redefine existing power relations. The political nature of community participation has further been camouflaged by another, similar term, "home as the first hospital" (WHO, 2000b), making it difficult to challenge governments when they offload their responsibilities onto their citizens.

Research Approach

Because my goal was to understand the personal experiences of the *Dai*s, I knew that quantitative research, although valid, would not capture their lived experiences fully. Tomm and Hamilton (1988) noted:

> The assumption that knowledge consists only in procedural, analytic knowledge and not in subjective, nondiscursive knowledge underlies much of the hermeneutical bias found in scholarship. This unbalanced theory of knowledge influences research in all areas and sharply reduces interest in much of what is of concern to women. Indeed, the argument here is that all persons have knowledge only when it is grounded in subjective experience and that this experience is given meaning through description. (p. xviii)

This is the kind of data, which, according to Wilkinson (1996), escapes statistical calculations. Therefore, in this study, efforts have been made not to let subjective, experiential data become invisible, but instead to complement the descriptive statistics. This study tries to achieve a balance between individuals' voices grounded in experience, which provide a deeper understanding of who the *Dai*s are, and the statistical data that are measures of what *Dai*s do. The current literature, which has focussed on the impact of *Dai*s' care on women in the form of global population statistics such as infant mortality rate (IMR) and maternal mortality rate (MMR), has marginalised *Dai*s' actual contributions to the health system. As such, it has ignored the effect of their work on their social and economic well-being. This has further been reinforced, albeit inadvertently, by the ideal nature of the HFA.

Ogilvie (1993) noted that "context both enables and constrains opportunities . . . to contribute to the health of populations," and she observed that the "ahistorical, acontextual and atheoretical nature of most comparative studies [in health] is lamented" (p. 5). Although she did not negate the usefulness of comparative or context-specific studies per se, she noted that the former lead to unequal comparisons between countries because the path of development in each country differs, and likewise their initiatives for health reforms and programme development would also differ. Contextual studies, on the other hand, allow for an in-depth examination of a topic, although it may be deemed too focussed or narrow. This study integrates both the contextual (Gujarat, India) and the comparative. However, the comparisons are done within the local context.[1] Therefore, the limitations associated with comparative studies in health do not apply here. Instead, the comparisons of multiple perceptions should give rise to important insights into *Dai*s' work and their health. Perceptions are subjective; nonetheless, they form the collective realities of those who are experiencing them.

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[1] The participants include *Dai*s who are SEWA members and non-SEWA members (non-SEWA *Dais*), local health care workers and health officials, SEWA women, *Dai*s' family members and clients, and UN officials based in India.

This study will be an important contribution to future studies of work both in trans-cultural and cross-cultural settings. Indeed, the multiple perceptions about work will allow for comparisons of women's health issues in various settings to explore how work is defined and valued. Issues such as strategies used to improve women's informal work, income, visibility, political participation, empowerment, and decision-making process could be explored. The analysis could be used to examine the effect of global policies such as RCH, whether such policies result in tangible changes in women's lives. On the other hand, health status based on multiple perceptions of work does not provide quantifiable data to compare with previous findings on either health or work. Perceptions of work do not include data on *Dai*s' contributions in terms of the monetary value of their services and the savings accrued to the Gujarat health care system or the time that they spend on delivery cases in addition to their other work. However, this qualitative study provided a useful framework to guide the formulation of quantitative questions that demonstrated the real value of informal work and the burden assumed by community members, especially women. More important, the scale of the informal sector and its link (directly or indirectly) to the international markets need to be explored. In the case of *Dai*s and other indigenous midwives around the world, it would be useful to understand the issues behind their low pay, their increased responsibilities even though they are still considered as informal health care workers, the lack of basic equipment and referral services, and the absence of stable employment for them in the context of the global economy would be useful. Because women constitute the bulk of informal workers worldwide, comprehensive regulations could be enacted to protect women workers in the informal sector against wage discrimination, unsafe work environment, prolonged work hours, and absence of social security.

Another goal is to make my work accessible to both academics and nonacademics. To this end I endeavour to reduce jargon to avoid alienating readers. Jargon creates artificial boundaries of specialised knowledge that amount to disciplinary gatekeeping. In doing so, the stage is set in the creation of power and prestige, the 'haves' and the 'have nots,' and the distinction between the knower and the 'ignorant.' Stanley and Wise (1983) noted that the very format of social science writing erects barriers to the acquisition of knowledge:

> Written science, it would seem, must be seen as simply the direct communication of 'facts,' and not as the product of the *act* of writing. . . . We feel that deliberately to construct such a thing as the finished product itself is to place barriers between writers

> and readers. . . . We see existing 'difficult' or 'complex' (more than not [sic] 'badly written') social science texts as examples [that we should not emulate]. We do not want the act of reading to be an intellectual assault course, which only the especially athletic can get through. Too often this has been one of the ways in which women, as non-initiates, have been excluded from what passes for 'knowledge.' (p. 7)

Access to knowledge is an important issue for women who are unable to read or write or both, and many of SEWA members fall into either group (Rose, 1992; SEWA Annual Report, 1988). On their own and without access to information, they are unable to address their invisibility, exploitation, or lack of income and work security. The SEWA organisation plays a crucial role in assisting these women in gaining access to information. The organisation does this in various ways, which include annual fairs, meetings with leaders, literacy classes, specific work-training programmes, video programmes, and women's individual co-operatives (Rose, 1992; SEWA Annual Reports, 1988-1998). All these methods are to assist the women, including the *Dais*, to build their capacities (empowerment) and improve their skills and knowledge. The goal is to enable women to articulate their needs in order to address issues such as fair wages, gain recognition for their contributions to the economy (including health care), address gender discrimination, and achieve income and work security.

Similarly, my goal is to ensure that my research findings are accessible to SEWA women and to those who may be interested in SEWA or the *Dais*. In the past, SEWA has translated various works from English into Gujarati so that women who are able to read and write Gujarati are able to access information about SEWA. A dissertation written with minimum jargon would ensure that if a translation is made, it could be done easily. The translations could be adapted for the *Dais* into audiotapes by SEWA.

The Researcher

The Beginning of a Journey

My journey began in 1997 when I first came across a book titled *Where Women are Leaders: The SEWA Movement in India* (Rose, 1992). The SEWA women's accomplishments and their courage inspired me, and I realised that I wanted to work with SEWA. I wanted to be part of an organisation that made tangible, positive changes in women's lives in their struggle to survive. My journey became a reality when SEWA accepted my research plan to conduct my work in

Gujarat, India. Maps 1 and 2 on the following pages show the state of Gujarat in India and the cities where I did my fieldwork, as well as the location of SEWA in Gujarat and its influence both within India (the SEWA philosophy has spread to other parts of India) and in other parts of the world.

The SEWA story reflects the struggles and the courage of poor self-employed women in Gujarat (Rose, 1992). The acronym SEWA in English means the Self-Employed Women's Association, but it is the Hindi and the Gujarati translations that provide the true picture and the uniqueness of SEWA. SEWA means *service* in both languages. Since its inception in 1972, this women's organisation, composed entirely of poor, self-employed women, has continued to challenge the structures that exploit women while at the same time championing fair wages, employment, and social justice. It is all about fairness and about being empowered (SEWA calls this *capacity building*). It is about finding one's voice and charting one's destiny. In doing so, it is also about clearing the path for future generations of women. It is about creating opportunities for each other and for oneself. This is SEWA.

It may seem odd for someone such as I to feel overwhelmed about empowerment and opportunities because I appear to have both in order to pursue my studies at a tertiary level. However, even an institution such as the university, which promotes ideals of innovation, leadership, and truth in learning, has structures that silence the individual and encourage conformity. The university is not a separate entity from society. It is a microcosm of the society at large and reflects its values. It supports the global economy and the global culture to ensure its survival, thus perpetuating unequal relationships. Therefore it is not surprising that as a student in this august institution, I have experienced disempowerment.[2] My disempowering experience came about when I presented my qualitative designed proposal to the Medical Sciences Committee.[3] Members of this committee were concerned that qualitative research that included

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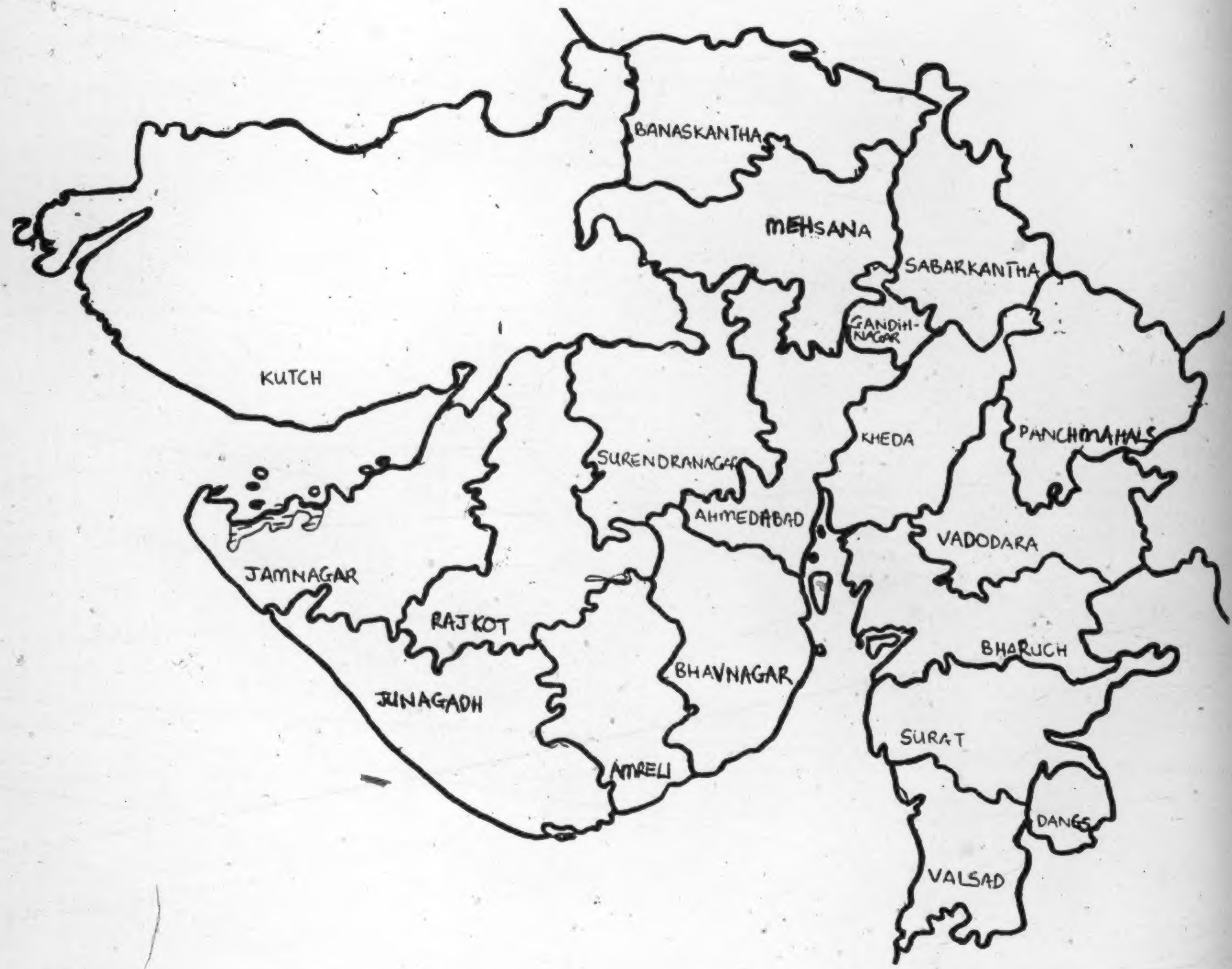
[2] I am including the personal because personal, lived experience is one aspect of knowledge. This stance is not unique but derives from feminist literature. For example, Tomm (1995) included her personal experiences to "facilitate clarity"; but more important, she felt that reporting the personal opens up "space for others to speak about their own spiritual experiences" and empowerment (pp. 8-9). See also Gibson (1995), Goer (1995), Griffin (1980), Luitel (1996), Prugl (1999), Register (2000), Tomm (1989), and Velez (2000). Thus personal voice(s) provide a foundation for this dissertation.

[3] The Medical Sciences Committee of the Faculty of Medicine and Dentistry is an adjudicating body that is comprised of medical doctors and staff from the various departments under the faculty. The Department of Public Health Sciences is one of the members.

CHINA
(TIBET)
PAKISTAN
GUJARAT
INDIA
ARABIAN SEA
BAY OF BENGAL

Map 1. India.


BANASKANTHA
MEHSANA
SABARKANTHA
GANDHI-NAGAR
KUTCH
KHEDA
PANCHMAHALS
SURENDRANAGAR
AHMEDABAD
VADODARA
JAMNAGAR
RAJKOT
BHARUCH
BHAVNAGAR
JUNAGADH
SURAT
AMRELI
DANGS
VALSAD

Map 2. Gujarat state.

subjective experiences may not be rigorous or constitute legitimate knowledge because there was no hypothesis to prove or disprove it. I therefore had to present my research proposal in a format that included a hypothesis.

However, unknown to me at that time, this disempowering experience provided the insight to understand comparable powerlessness and exclusion of a group of women in whom I was interested, namely the *Dai*s of Gujarat. My experience taught me the effect of exclusion and invisibility, and I learned about the power of perceptions. I became aware of how perceptions can legitimise one idea over another if individuals who are power holders promote it.

I am stating my personal biases and beliefs about academic writing and knowledge at the outset so that readers will be aware of them. Shi (1997) advised researchers to do this so that readers will understand the constraints of the researcher and the limitations of the study. Marshall and Rossman (1995) asserted:

> A sensitive awareness of the methodological literature about the self in conducting inquiry, interpreting data, and constructing the final narrative helps, as does knowledge of the epistemological debate about what constitutes knowledge and knowledge claims, especially in the critique of power and dominance of traditional research. (pp. 17-18)

To contextualise myself in the dissertation, I relate my story—events I experienced in the field. Stanley and Wise (1983) noted that contextualisation enables readers to understand the researcher's actions and the outcomes of the research. In this way the research is not separated from the researcher but "occurs through the medium of a person—the researcher is inevitably present *in* the research" (p. 179).

The Organisation of the Dissertation

My dissertation is organised in the following way: Chapter 1 introduces the research, including the context, goal, and objectives and the frameworks. Chapter 2 outlines the theoretical frameworks that I use to guide my discussion about the *Dai*s' work and health. Chapter 3 describes the Gujarat health care system and its health work pertaining to women's health. Chapter 4 discusses SEWA. Chapter 5 reviews the literature on work and indigenous midwives around the world, including the *Dai*s of India. Chapter 6 describes the various methods I used during my fieldwork to answer the questions about work and perceptions. Chapter 7 introduces the data findings and the emerging issues. Chapter 8 examines the relationship between *Dai*s' work and health. And the final chapter brings all the issues together and suggests some policy changes to ensure that the *Dai*s' contributions and health become an integral part of Gujarat's Reproductive and Child Health (RCH).

CHAPTER 2

THEORETICAL FRAMEWORK

Introduction

In this research, the health of *Dais* is explored relative to their work. Because *Dais* are informal (self-employed) workers, the effect of their work and income on their health is profound. Questions such as to what extent their involvement in the health care system provides them with income and work security as defined by the RCH are relevant. The joint WHO/UNICEF (WHO, 1978) *Primary Health Care: Health for All by 2000* (HFA) and the WHO/UNFPA/UNICEF (henceforth WHO, 1992) *Traditional Birth Attendants* present contradictory statements about the role of indigenous midwives in the formal health care system. However, they agree that midwives are included because they fulfil the needs of the formal health system: they bridge the gap until the health infrastructure is able to meet the needs of the population.

This research is an attempt to understand the link between the health and work of the *Dais*. The exploration follows closely with the social determinants of health. Research shows that unemployment or lack of work security causes ill-health and social exclusion (Bartley, Ferrie, & Montgomery, 1999; National Forum on Health [NFH], 1997; Sen, 1999, 2000; Shaw, Dorling, & Davey Smith, 1999; Sorlie, Backlund, & Keller, 1995). Individuals who suffer from poor socioeconomic status experience deprivation that leads to premature death, suicide, material constraints, poor nutrition and housing, and anxiety (Shaw et al., 1999). Although the link between unemployment and ill-health has been established both in SEWA's work and elsewhere (Davey Smith, 1996; Haggerty & Johnson, 1996; Karasek et al., 1988; Kuate Defo, 1997; Marmot & Davey Smith, 1989; NFH, 1997; Sorlie et al, 1995; Wilkinson, 1992a, 1992b, 1996), this research explores how perceptions of work impact health.

Setting the Context for Understanding Health

I use three landmark documents, together with the SEH framework, to situate the relationship between health and work. The documents are the above-stated WHO/UNICEF (WHO, 1978) HFA, the *Ottawa Charter for Health Promotion* (1986), and the International

Conference on Population and Development (ICPD), which formulated the *Reproductive and Child Health policy* (RCH; UNFPA, 1994).[4] There are three reasons why these documents are useful to this research. First, they recognise that universal health continues to be out of reach for many people around the world, and they provide broad strategies towards achieving universal health, one of which includes community participation. Community participation at all levels through decentralisation and appropriate use of various resources to make health care affordable and accessible is a long-term goal of India and Gujarat. The utilisation of indigenous practitioners such as the *Dai*s meets all the objectives towards achieving universal health, because they are affordable, accessible, and appropriate. Their involvement in health care fits well with the second reason, which is linked to the broad definition of health. Issues such as promoting gender equity, women's empowerment, and participation, and creating opportunities for the vulnerable sections of the population come under the purview of social health. Taken together, these documents provide the groundwork for an exploration of whether the *Dai*s' involvement in Gujarat's health care promotes *Dai*s' health within a socioeconomic framework.

The opportunity to evaluate these documents provides the third reason for their usefulness. Evaluating them reveals that despite their inclusive language, they do not promote an equitable relationship between the indigenous midwives and the formal health care system. Instead, their language disempowers the midwives because they are perceived as a short-term solution to a long-term problem and not as integral members of the health care system. The documents do not outline strategies to include these healers in the formulation of health policies or how they could become formal health care providers. The global language of the frameworks assumes that the indigenous midwives will be willing to be involved and contribute to health care without examining the potential impact on their well-being such as loss of income or status.

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[4] The Health for All (HFA) was held in Alma-Ata in 1978, organised by the WHO. The Ottawa Charter, which shifted the focus from curative health to preventive health and health promotion, was organised by WHO, the Canadian Public Health Association, and Health and Welfare Canada. The conference was a "response to growing expectations for a new public health movement" and focussed on the needs of the industrialized nations, building on the tenets of the PHC. The International Conference on Population and Development (ICPD) was held in Cairo in 1994, and it led to health policies of Reproductive and Child Health (RCH): RCH broadened the concept of reproductive health into a life-cycle approach from conception to menopause. Although male participation in health is not new (the other two had touched upon this), the ICPD conference made it clear that, for RCH philosophy to succeed, male participation is crucial in the overall health of women.

The Socioeconomic Determinants of Health Framework

The socioeconomic determinants of health framework (SEH) provides a useful framework to explore health from multiple perspectives. The basic premise of the SEH is that there is a link between social and economic inequities and ill-health (Andrulis, 1998; Bailis, Segall, Mahon, Chipperfield, & Dunn, 2001; Bartley et al., 1999; Bartley, Power, Blane, Davey Smith, & Shipley, 1994; Csaszi, 1990; Davey Smith, 1996; Haggerty & Johnson, 1996; Kalkhoff & Barnum, 2000; Kanji et al., 1991; Kaplan, Pamuk, Lynch, Cohen, & Balfour, 1996; Kawachi et al., 1997; Kennedy, Kawachi, & Prothrow-Smith, 1996; Kuate Defo, 1997; Kwangkee & Moody, 1992; Lynch, Kaplan, & Shema, 1997; Marmot & Davey Smith, 1989; Marmot et al., 1991; Morris, Bernhardt, & Handcock, 1994; Najman, Bor, Morrison, Andersen, & Williams, 1992; NFH, 1997; Pincus, Esther, DeWalt, & Callahan, 1998; Poland et al., 1998; Sorlie et al., 1995; Sen, 2000; Wilkinson, 1992a, 1992b, 1996). Proponents of the SEH say that deprivation (perceived or real) due to economic disparity and social inequities affects the health of individuals. Individuals may experience deprivation due to low income or unemployment or perceive that they are socially or economically marginalised relative to others in society. In both cases the outcome is deleterious to the individuals' health. In the case of unemployment, deprivation could also lead to social exclusion and a breakdown of social cohesion (Sen, 2000). Economic factors appears as the root cause of ill health, with ramifications for social and physical health such as low self-esteem, inability to cope, high crime rates, suicide, poor nutrition, and heart diseases. One of the most compelling pieces of evidence regarding the long-term negative effects of deprivation is the impact on children's development. Studies have shown that children who experience sustained deprivation during the first years of life have poor development, are unable to cope during adulthood, and have poor self-esteem (Bartley et al., 1994; Najman et al., 1992; NFH, 1997). In addition, wide income disparity affects the infant mortality rate (IMR), life expectancy at birth, and the life expectancy at age 5 (Kennedy et al., 1996; Najman et al., 1992; NFH, 1997; Rodgers, 1979). The NFH (1997) concluded that "the environmental stresses and psychosocial deprivations that accompany poverty can undermine the development of the child and negatively affect competence and health in the long-term" (p. 10). Hence, the SEH encourages the investigation of ill-health beyond the disease-causing factors and shows that income inequality places the burden of poor health on those who already experience some level of deprivation (Davey Smith, 1996; Lynch et al., 1997; Najman et al., 1992; Pincus et al., 1998; Wilkinson, 1992b, 1996). Pincus et al. observed that individuals' social conditions and degree of control are more influential in affecting health than is access to care. They noted that those who are from a high socioeconomic level use health services less than those who have low income. Although Pincus et al. attributed this difference to the ineffective use of health services by the poor, other authors pointed out that it is due to the fact that these individuals are often unwell (Csaszi, 1990; Kaplan et al., 1996; Kawachi et al., 1997; Kennedy et al., 1996; Kibirige, 1997; Kuate Defo, 1997; Lahelma & Valkonen, 1990; Pannarunothai & Mills, 1997). Their ill health ranges from the physical effects of deprivation to social and psychological impacts of that deprivation. Thus Wilkinson (1992a) noted:

> Increasingly social scientists have emphasised the importance of relative poverty and of the way it excludes people, socially and materially, from the normal life society. . . . But the sense of relative deprivation, of being disadvantaged in relation to those better off, probably extends far beyond the conventional boundaries of poverty. . . . The social consequences of people's differing circumstances in terms of stress, self-esteem, and social relations may now be one of the most important influences on health. (p. 168)

In other words, although low income or unemployment in themselves have an adverse effect on individuals' health, it is the social and psychological outcomes of this inequity that have a greater impact on individuals' well-being; that is, how one perceives one's position in society relative to others and whether one feels included, excluded, or connected influences one's well-being. Sen (2000) noted that persistent unemployment leads to gender and racial inequality, social exclusion, and other losses such as cognitive ability, confidence, skill, human relations, and self-esteem. He argued against the perception that social security such as unemployment insurance offers some form of financial support and removes the negative effect of long-term unemployment. Sen asserted that not only does long-term dependence on unemployment insurance place the burden on the public, which has adverse consequences on the economy, but also the social and psychological burden that individuals experience cancels the benefits of the social safety net. Furthermore, Sen contended that there is a motivational loss to seek future employment and a growing sense of cynicism. He observed:

> There is also evidence that large-scale unemployment has a tendency to weaken some social values. People in continued unemployment can develop cynicism about the

> fairness of social arrangements, and also a perception of dependence on others. These effects are not conducive to responsibility and self-reliance. The observed association of crimes with youth unemployment is, of course, substantially influenced by the material deprivation of the jobless, but a part is played in that connection also by psychological influences, including a sense of exclusion and a feeling of grievance against a world that does not give the jobless an opportunity to earn an honest living. In general, social cohesion faces many difficult problems in a society that is firmly divided between a majority of people with comfortable jobs and a minority—a *large* minority—of unemployed, wretched, and aggrieved human beings. (p. 22)

On the other hand, Wilkinson (1992a, 1992b, 1996) and others (Kaplan et al., 1996; Kennedy et al., 1996; Marmot & Davey Smith, 1989) noted that individuals who live in countries or states that have a narrow income gap tend to have a longer life expectancy and lower mortality rates. This is because these countries would most likely have better public services and institute economic and social policies to address the inequities. They would also be the ones to invest heavily in developing their human resource. Studies conducted in the US that compared health outcomes and income distribution showed that states that have greater inequality in income distribution report higher rates of violence and more disability and have more individuals without basic health insurance and less investment in education and literacy—all of which translates into adverse psychosocial health outcomes (Bailis et al., 2001; Kaplan et al., 1996; Kennedy et al., 1996; Sorlie et al., 1995). Kennedy et al. noted that economic policies that rely on the trickle-down effect to benefit the poor and those at lower income levels often do not achieve the intended goal, and instead widen the gap further. They suggested that governments institute policies that allow for more equitable distribution of income to narrow the gap and address negative health outcomes in the population. Japan provides one of the best examples of how narrow income distribution mediated through the Confucian and Buddhist ethics of care and social responsibility does indeed lead to social cohesion, increased life expectancy, lower mortality rates, and, at the same time, the enjoyment of economic prosperity (Marmot & Davey Smith, 1989; Wilkinson, 1992a, 1996). Thus, Japan's high economic growth and social cohesion debunk the common myth that policies that promote equitable economic and social environments would dampen the competitive edge of the economy. Instead, it shows that it leads to greater financial growth when people feel that they have a stake in their future.

The psychosocial effect on health from financial and material insecurity is one of the main findings that is emerging from developed countries. Using the SEH framework, various studies show that, apart from unemployment, negative health outcomes also stem from the effects of persistent job and income insecurity, the lack of control over one's work, and the perception of being employed in low-scale work (Bailis et al., 2001; Bartley et al., 1999; Blane, 1995; Kanji et al., 1991; Kibirige, 1997; Marmot et al., 1991; NFH, 1997; Pincus et al., 1998; Shaw et al., 1999; Wilkinson, 1996). Thus it is one's position (socially and financially) relative to the overall society that leads to the perception of being either better or worse off, which in turn impacts one's health. Wilkinson summed up the intrinsic relationship between money, sense of control and health as follows:

> In many ways money is the key to the ability to control one's life. The more money, the greater one's options, the more choice and the more easily most problems can be overcome. Indeed, problems of job or housing insecurity may be seen as instances of a more general category of financial insecurity where important areas of control are lost. The importance of social support also transfers to the world outside work. (p. 182)

Sen (1999), on the other hand, referred to this sense of control and the ability to make choices as *agency*. According to him, agency leads to a state of well-being because it enables individuals to become agents of change—which in itself promotes health—and not merely recipients of welfare. Although this observation applies to both males and females, Sen indicated that women have to overcome additional barriers, more so in highly stratified societies before they become agents of change. Thus women's agency is enhanced through education, the ability to earn independent income, employment outside the home, and ownership rights (Mehra, 1997; Sen, 1999). All these strengthen their relative position both within the home and outside and lead to their empowerment, because together they influence the perception of who is "contributing" or doing "productive" work (Sen, 1999, p. 193; Mehra, 1997).

The recurrent theme in all of the literature that used the SEH framework to explore health is that it is the perception of one's socioeconomic position relative to that of others that affects individuals' well-being. The SEH framework has enabled researchers to link income disparity and ill health with the need to establish policies that would assist in ameliorating the inequities. In this respect, WHO's definition of health (and for that matter the RCH framework for reproductive health) and the steps to promote health for all, appear to fit well with the suggestions put forth by researchers using the SEH framework. These include community participation to enhance and increase social cohesion, remove barriers that impede individuals' economic and social agency, and institute public policies that meet the needs of those who are marginalised in society.

A Critical Evaluation of the SEH Framework

Like all theoretical frameworks, the SEH has both strengths and weaknesses. Its strength lies in showing the link between health and socioeconomic factors, thus moving beyond biomedical causes. In doing so, the emerging data point to the need to correct structural issues that lead to unemployment, job insecurity, discrimination, poor or inadequate housing, inadequate health infrastructure, illiteracy, and the lack of opportunities to realise aspirations. Wilkinson (1996) and Sen (2000) maintained that it is crucial to understand how individuals perceive their position relative to that of others because this determines whether they feel that they have the locus of control, a range of choices, and the ability to direct their actions. In addition, the SEH model shows that there is a link between societal structures and the health of the individual.

The SEH framework is predicated on the assumption that individuals use their monetary level to measure their level of well-being and that disparity of income is the starting point for many health problems. This is a narrow interpretation of health and factors that contribute to good health. The SEH ignores those societies that either do not place a high value on money and level of income or societies that consider reciprocal ties as more prestigious, and where the possession of wealth could be perceived as socially disruptive and able to break down social ties. Thus the SEH is biased towards a capitalist notion of health and does not consider other worldviews and other perceptions of well-being.

In terms of the SEH framework's generalisability, its usefulness has so far been demonstrated in studies conducted in the North.[5] The results indicate that in the North it is the position of individuals relative to their income disparity that impacts health. Although it is important to distinguish between relative and absolute income, the basic outcome of disparity in both instances is negative because it affects the individual's agency and choice. And yet the results presented by Wilkinson and others seem to indicate that this is a new phenomenon in the

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[5] The term *North* refers to developed countries, many of which are found in the Northern Hemisphere; and *South* refers to developing nations, which are generally found in the Southern Hemisphere. These labels are used in an attempt to move away from the value-laden references attached to labels such as *developing* and *developed.*

North. Indeed, one has to observe the poor segments of the population in the North and in the South, where poverty is prevalent, to know that this state is not conducive to good health.

The authors who used the SEH framework have failed to examine the relationship between environmental sustainability, economics, social structures, and health. Although they were able to link economics and the effects on psychosocial health, they did not examine the effect of environmental degradation on health. Issues such as the impact on a population's health when there is mass migration (forced or voluntary) and when a segment of the population would be affected more than others, and the long-term effect on the economy and on social relations (ethnicity, immigration, gender) are not addressed. Linked to environmental sustainability and economics is the issue of increased permeability of international boundaries as a result of trade (goods, services, and knowledge) and the effect on health. None of the studies addressed the effect of international trade on health, whether it promotes the health of citizens of one country or adversely affects those of another, especially if the relationship is unequal. Other external influences that are excluded in the discussion of health are the involvement of the major drug companies and their influence on local and international health policies. And except for development literature where the link between health and structural adjustment policies promoted by international lending agencies was noted (Kanji et al., 1991), the literature using the SEH framework to examine health and socioeconomic factors is silent about this link to citizens' health.

Because the major premise of the SEH is that income disparity is the cause of ill health, research has suggested that governments should address this inequity. Again, the concrete steps needed to address this income disparity to ensure that economic and social health and political participation are enjoyed by everyone are not discussed. Instead, there are general statements to address this income disparity (Poland et al., 1998). Countries such as Sweden and Japan are used to show that a narrow income gap does lead to a better health profile. However, it could be that the population is generally 'homogeneous,' unlike highly stratified societies in which factors such as caste, religion, and gender stratification could play a role to widen the social and economic divisions. In these countries, competing interests of stakeholders could impede the move to reduce social and income disparity. In these instances, the inequities may be related not only to economics but also to intangible factors such as opportunities to realise one's aspirations and dreams, freedom, social cohesion, social support, and feeling content, all of which promote psychological health.

Despite the narrow interpretation of the SEH framework, the important underlying idea is that health is linked to both the social and the economic structures of a society. This framework enables researchers to examine the concept of good health using a broad framework that allows a more holistic view of health than the biomedical view of diseases. In doing so, there is a greater understanding of why there continue to be large segments of the population who do not enjoy good health despite increased expenditures in health care. The findings through the SEH framework also represent a shift from blaming the victim to examining the larger social environment to understand what contributes to good health or the lack thereof. In conclusion, the SEH framework provides a good base from which to understand the WHO and UNFPA RCH visions of good health.

Primary Health Care: Health for All (HFA) and the Ottawa Charter

According to the Alma-Ata Declaration of WHO (1978), health is

> a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to health care. (p. 2)

Building on the foundation of the Alma-Ata, the *Ottawa Charter for Health Promotion* took on a more encompassing view of health. It defined health promotion as

> the process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being. (p. 1)

The *Ottawa Charter* (1986) identified the prerequisites for health that move beyond the causes of disease by focussing on the socioeconomic aspects of living, such as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, and social justice and equity. The

WHO/UNICEF's (WHO, 1978) HFA noted that primary health care "is part of social development and in the spirit of social justice. . . . The purpose of development is to permit people to lead economically productive and socially satisfying lives" (pp. 37-44). Indeed, despite the difference in wording, the underlying message in both documents is that everyone has the right to lead a healthy life, and one of the ways that this can be achieved is to have access to affordable and appropriate health services.

Accessible, affordable, and appropriate health services could be achieved through active participation of individuals in a community and their control over the resources. This means working under the premises of self-reliance and self-determination. Thus the Alma-Ata Declaration (WHO, 1978) defined *community participation*:

> Self-reliance and social awareness are key factors in human development. Community participation in deciding on policies and in planning, implementing, and controlling development programmes is now a widely accepted practice. . . . Community participation is the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their and the community's development. They come to know their own situation better and are motivated to solve their common problems. This enables them to become agents of their own development instead of passive beneficiaries of development aid. They therefore need to realize that they are not obliged to accept conventional solutions that are unsuitable but can improvise and innovate to find solutions that are suitable. (p. 50)

The *Ottawa Charter* (1986) referred to the same philosophy of community participation as strengthening community, which it outlined in the following way:

> Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities—their ownership and control of their own endeavours and destinies. . . . Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters. (p. 3)

As noted, despite the differences in wording there are some common, central issues. Both emphasise a multisectoral approach to health with people at the centre and individuals as a key resource. In addition, there is also an underlying belief that successful implementation of the broad tenets and community participation can occur if there is a power sharing with people and all the other sectors including government (national and local), non-governmental organisations (NGOs), and international funders and agencies. Furthermore, there must be a clear national policy to ensure cohesion of various efforts from the local to the national and international levels (WHO, 1978).

The groundwork laid out for active citizens' participation and for accessible, affordable, and appropriate health care has important implications for the development of human resources. In this instance the HFA (WHO, 1978) noted:

> For many developing countries, the most realistic solution for attaining total population coverage with essential health care is to employ *community health workers* who can be trained in a short time to perform specific tasks, . . . may be required to carry out a wide range of health care activities, or, alternatively, their functions may be restricted to certain aspects of health care. . . . In many societies it is advantageous if these health workers come from the community in which they live and are chosen by it, so that they have its support. (p. 62)

Thus one of the human resources to which the HFA referred is the traditional medical practitioners.[6] It observed:

> Traditional medical practitioners and birth attendants are found in most societies. They are often part of the local community, culture and traditions, and continue to have a high social standing in many places, exerting considerable influence on local health practices. With the support of the formal health system, these indigenous practitioners can become important allies in organising efforts to improve the health of the community. Some communities may select them as community health workers. It is therefore well worth while exploring the possibilities of engaging them in primary health care and of training them accordingly. (p. 63)

Other individuals include family members, particularly women "in view of their central position in the family; this means that they can contribute significantly to HFA especially in ensuring the application of preventive measures" (WHO, 1978, p. 64). Besides women, others who should be involved in health promotion are women's organisations, young and old people, and men. The HFA noted that men should be included "to help them realize that they can contribute by shaping the community health system as well as by taking part in practical undertakings" (p. 64). Both the HFA and the *Ottawa Charter* recognised that health work is possible if there are adequate infrastructures to ensure "safer and healthier goods and services, healthier public services" (p. 2). Both documents concluded that greater co-operation within and between countries will make 'Health for All 2000' a reality as part of overall social, economic, and political development and will promote self-reliance.[7]

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[6] The roles of the indigenous healers, in particular the midwives, are discussed in Chapter 5.

A Critical Evaluation of WHO's Health for All (HFA) by 2000 and the Ottawa Charter[8]

The main criticism of the Alma-Ata Declaration of HFA and the *Ottawa Charter* is that they are broad and nonspecific, which makes their implementation difficult. Stone (1986) noted that "while the moral bases of the PHC [primary health care] are beyond reproach, PHC is understandably fraught with difficulties in the real and less lofty world of national and international development" (p. 293). The goal of HFA was to establish a philosophy that was applicable to the majority of the countries. Each country could find salient points of reference that they could use to integrate primary health care and work towards universal health. Therefore the HFA formulation was a response to the growing disillusionment of health care delivery in both the South and the North—between China's "barefoot doctors"[9] and the increasing health care costs in the US (Venediktov, 1998). It was envisioned that initiatives stemming from the HFA framework would be the first point of contact between the population and the national health care system (Venediktov, 1998). However, due to their nonspecific and global nature, the guidelines are subject to broad interpretations and misinterpretations.

The broad and idealistic guidelines lack the power to ensure that countries adhere to them and are accountable. Questions such as how countries will be accountable for their actions, what guidelines (if any) there are to monitor each country's progress, and to whom these progress reports should be sent were not addressed in the framework of the HFA. These are difficult questions in part because of WHO's structure and role. WHO's role is not to intervene directly but to act as an advocate and a technical advisor, assisting countries in implementing their long-term health policies through working with national governments (Godlee, 1994). However, this means that WHO has no direct powers to improve individuals' health, and the organisation relies on the goodwill and receptiveness of the countries with which it works (Godlee, 1994). Godlee observed that "'Health for All by the Year 2000' has entered the international vocabulary but few people, apart from diehard enthusiasts in the organisation, believe the target can be realised or understand how WHO intends to achieve it" (p. 1424). Thus one of the criticisms levelled at WHO is that it lacks both a clear strategy and authority in implementing its goal (Godlee, 1994).

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[7] Although 2000 has passed and millions are still without basic health care, the concepts are still valid.

[8] I will base my critical evaluation on the HFA because the Ottawa Charter follows closely on this document.

[9] Citizens who were given training to provide basic health care in their village, at the doorstep.

In the Declaration, WHO (1978) also assumed that the goal of all individuals is good health and that everyone will work towards achieving it. Therefore the HFA did not address the issue of individuals who deviate from this goal. One example is smoking. Although it is a well-known fact that smoking is harmful to health, more and more individuals are taking up smoking, especially teenage women. The HFA pointed out that access to information is important to ensure that people can make the right choices. And yet the reality is that despite access to information (as in the case of smoking), individuals continue to engage in harmful behaviour. Linked to access of information is the issue of literacy and the availability of information in a language that may not be understood by individuals in certain regions. The HFA did not address how these obstacles could be overcome or recognise that these could hinder access to information.

Another assumption that the HFA (and the *Ottawa Charter*) made is that individuals and communities are willing to be active participants in their health and control the resources. However, it did not specify how participation should be operationalised, who decides the control of resources, and how the resources will be allocated to ensure a fair and equitable distribution. More important, the HFA failed to mention whether community participation is culturally relevant and, if so, how to ascertain the community's understanding of participation. Using a historical and political-economic perspective, Morgan (1990) examined the extent of community participation in Costa Rica's primary health care. She noted that although primary health care in Costa Rica is held as a model of success, community participation is absent. This is because community participation was not part of the local health scene before the mid-1970s. Morgan observed that Costa Rica's historical data on health show no precedence of the extent and the type of participation sought by the WHO primary health care guidelines. She went on to say:

> Participation was a concept introduced by the United States and promoted by foreign aid agencies to promote a Western democratic political ideology. Once the ideological function had been served, and the contradictions of state-sponsored community

> participation had been revealed, the concept was abandoned by the agencies and the Costa Rican government. . . . The experience exemplifies the complexities and social contradictions that emerge when a small, economically-dependent country feels the need to adopt externally-sanctioned models when structuring rural health services. (p. 211)

Morgan concluded that when community participation threatened the power bases of the elite in Costa Rica, it was discouraged and abandoned.

The Alma-Ata Declaration was silent on the issues of power, exploitation, and marginalisation. It did not take into account that those who are in positions of power will play a dominant role to allocate resources that may not reach those who really need them. Thus the neutral language of community participation actually hides the power of domination and assumes that all health work is agenda free, based on the notion of greatest good for the greatest number of people (Foster, 1987; Morgan, 1990; Navarro, 1984; Pigg, 1995, 1997; Stone, 1986, 1992). Both Foster and Stone noted that the rhetoric of community decision making hides the fact that *a priori* decisions have already been made by the policymakers on the target populations and the implementation of the health strategies. Foster's experience at WHO illustrated this point well:

> At high levels within WHO behavioral research may also be used as a validating device to supply the evidence that policy enacted is in fact the correct policy. This became clear to me 10 years ago when I worked with a small group in Geneva on a background paper on community participation in Primary Health Care, for use at the 1978 Alma-Ata PHC conference. It was generally accepted, as a WHO staff member reminded me, that "Our purpose is to prove that community participation in Primary Health Care is the correct way to achieve health for all." Our report, which summarized the evidence from carefully selected studies, certainly conveyed the impression that research demonstrated conclusively that community participation was a very important element in building PHC at local levels. (p. 716)

The Declaration (HFA) further ignored the power differentials and the complex relationship between genders and assumed that there is equity and a clear division of labour in health. Thus the document neatly divided the roles for both men and women in carrying out the HFA while placing the onus of health squarely on women who, "in view of their *central position* in the family, . . . can contribute significantly to PHC especially in *ensuring the application of preventive measures*" (p. 64; emphasis mine). The HFA was vague on men's role, only alluding to it as "*practical undertakings*" (emphasis mine) without being clear as to what these practical undertakings actually entail and the impact of these undertakings. This precise division certainly does not hold true in South Asia, where men are the formal power holders who influence the decision-making process in health (Jejeebhoy, 1995; Joshi et al., 1997; Kishore, 1995; Murthi, Guio, & Dreze, 1998; Narayana, 1998; Neelsen, 1991; Patel, Barge, Kolhe, & Sadhwani, 1994; Ramasubban, 1995; *Times of India*, 2001a, 2001b).

The HFA also made similar assumptions that there is a symbiotic and equitable existence between the biomedical health care system and the indigenous health model. Stone (1986, 1992) and others (Gibson, 1995; Irwin & Jordan, 1987; Jordan, 1978/1993, 1989; Morgan, 1990; Pigg, 1995, 1997) showed that this is not often the case in many parts of the world. There is a constant power struggle between various healers to create a niche for healing and knowledge. For example, in Costa Rica doctors worried that their professional control would be threatened and co-opted by paraprofessional health workers (Morgan, 1990). Related to the role of indigenous healers is the assumption that they are powerful and wield great influence on the process of healing and that people are passive consumers of health. Stone's findings in Nepal show that this assumption is not universal. She found that people control their health in various ways, one of which is the way in which they establish and negotiate their relationship with the indigenous healer and the extent of the healing ritual.

Other issues that the HFA did not address include how universal health could be conceptualised in countries which are either colonised or undergoing decolonisation, or in the event that there are political, social, and economic upheavals such as war, or in the world economy. And although international co-operation and NGO involvement sounds encouraging, there is a potential for the national government to abdicate its social responsibility, become unaccountable for the mistakes, and continue a 'piecemeal' development due to the uneven distribution of resources including funding. Furthermore, NGOs are limited in the extent to which they can implement HFA compared to the national governments.

Reproductive and Child Health[10]

The 1994 ICPD builds on the 1974 World Population Conference in Bucharest and the 1984 International Conference on Population in Mexico City.[11] The aim of ICPD is to link population with development, focussing on individuals' well-being and steering away from the usual target setting to control population growth (UNFPA, 1994). The *Reproductive and Child Health* (RCH) principles, based on a broad mandate, encompass empowerment of women through education, employment, skills development, access to health services, and the removal of social, political, and economic inequities that impede women's progress.[12] Similar to the HFA, RCH recognised that individuals "are at the centre of concerns for sustainable development, since people are the most important and valuable resource of any nation" (p. 7). This being the case, couples and individuals have the "right to decide freely and responsibly the number and spacing of their children, and to have the information, education and means to do so" (p. 7). According to the RCH,

> reproductive health is a state of complete physical, mental, and social well-being in all matters relating to the reproductive system and to its functions and processes. It implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so. (p. 13)

Unlike the vague tenets of the role of males in the HFA, RCH (UNFPA, 1994) was very clear about the role of men in the arena of population and development. It noted:

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[10] The ICPD conference was organised by the UNFPA. The framework of Reproductive and Child Health (RCH) was formulated at this conference.

[11] Implementation of the ICPD's Programme of Action is part of an integrated follow-up effort of the following international conferences: **WHO Health for All,** Education for All, the World Summit for Children, the Conference on Least Developed Countries, the UN Conference on Environment and Development, the International Conference on Nutrition, the World Conference on Human Rights, the Global Conference on the Sustainable Development of Small Island Developing States, the World Summit for Social Development, the Fourth World Conference on Women, and the Second UN Conference on Human Settlements (Habitat II).

[12] The ICPD goal encompasses the following objectives: sustained economic growth in the context of sustainable development; education, especially for girls; gender equity and equality; poverty eradication; reduction in infant, child, and maternal mortality; and universal access to reproductive health services, including family planning and sexual health. Other issues include understanding the relationship between population and the environment, unsustainable consumption and the rights of migrants and refugees, and the population and development of indigenous peoples.

> Men play a key role in bringing about gender equality since, in most societies, they exercise preponderant power in nearly every sphere of life. . . . Innovative programmes must be developed to make information, counselling, and services for reproductive health accessible to adolescents and adult men; . . . must both educate and enable men to share more equally in family planning, domestic and child-rearing responsibilities and to accept major responsibility for the prevention of STDs. (pp. 10-13)

All countries must strive to make reproductive health care services accessible, available, acceptable, and affordable through primary health care. This is to alleviate the high annual maternal mortality, particularly in the 'developing' countries, where 99% of the world's 600,000 female deaths occur (UNFPA, 1994; WHO, 1999a). In addition to the availability of health services, RCH further stated that early education (both formal and informal) is a must for boys to ensure that there is a change in attitude towards women and girls. Other steps that should be taken to ensure development and reproductive health are the eradication of poverty, because "women are the poorest of the poor" (UNFPA, 1994, p. 8), and the involvement of women as full participants in policy development and implementation; hence "efforts should be made to recruit and train more female researchers" (p. 22) and to focus on sociocultural and economic research that are relevant to the population policies and programmes.

The RCH adopted a similar view to that of the HFA regarding the involvement of other agencies and organisations. It encouraged partnerships amongst NGOs, national and international governments, and the private sectors to promote development and reproductive health. Thus one form of partnership is the monetary assistance from the international community to 'developing' countries and countries with economies in transition. The participants at the ICPD (UNFPA, 1994) decided that

> governments and donor countries should ensure that NGOs and their networks are able to maintain their autonomy and strengthen their capacity through regular dialogue and consultations, appropriate training and outreach activities, and thus play a greater role in the partnership. . . . The aim is to strengthen the partnership between governments, international organisations, and the private sector in service delivery and in the production and distribution of high quality reproductive health and family planning commodities and contraceptives. The profit-oriented sector should consider how it might better assist non-profit NGOs in playing a wider role in society by enhancing or creating mechanisms to channel financial and other support to NGOs and their associations. (p. 25)

Thus the overall aim is to bring about a sustained social, economic, and political development that would promote the reproductive health of individuals (females and males) around the world; in essence, a 'Reproductive Health for All.'

Reproductive and Child Health (RCH): Same Product, New Packaging?

It appears that the RCH, HFA, and *Ottawa Charter* have common themes to guide health work. These include the underlying belief that individuals are an integral part of any health policies both as recipients and a resource. Thus phrases such as *empowerment, inequity/inequality*, *community participation*, *access to resources and information*, *eradication of poverty and discrimination*, and *affordable, accessible, and appropriate health care* are inherent in all the documents. However, there are differences between RCH and the HFA.

The RCH stated that, because men are the power holders, their participation is essential to bring about women's development. Its recognition that men play a role in the outcome of women's reproductive health, and therefore should assume responsibility for their sexual behaviour, is a marked improvement from the vague statement in the HFA. Not only was there a recognition that uneven power distribution is a factor in health, but also the onus of reproductive health was placed on both of the genders instead of on women alone. Male participation, however, could end up in a similar state to that of community participation in Costa Rica—that is, absent—if it is not part of the overall culture to begin with. The ICPD's (RCH) proposal of shifting power distribution can 'upset' the power of the men and the social balance. Therefore educating young boys is imperative to change this mindset. But it is equally important to educate women to ensure that this shift occurs. One example will illustrate my point. During my fieldwork, one of the questions that I asked was about contraceptives. When I proposed that instead of women assuming the burden of sterilisation (tubal ligation), men could shoulder this burden of contraception, it was the women who opposed the move. They pointed out to me that vasectomies are detrimental to their husbands because it makes them weak and 'unable to work.'[13] Similar to the HFA, the RCH did not address the obstacles to the implementation of its objectives.

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[13] 'Unable to work' has multiple meanings. Aside from the inability to do physical work, it also means impotent and unable to have sexual intercourse.

One example is the belief that couples have the right to decide the number and spacing of children. This is again related to the assumption that there is equal power sharing between genders. But in many parts of the world such as South Asia this is not the case. The decision to have children is not a private matter nor an individual decision made in a vacuum. In India, for example, this decision lies with the extended family (usually the parents-in-law), the need to maintain and continue family lineage, the community, and then the couple.[14] Overarching these is the role of the state in controlling the decision through its punishment and reward system. The RCH's goal appears to have been based on the Western perception of childbirth and is not applicable to many parts of the world. The RCH, however, presumed that information is neutral and agenda free and that everyone has the same information to make the right choices, and with the same information, they will make similar choices.[15]

Another shift found in the RCH is the definition and the understanding of reproductive health. Instead of defining it within a narrow time frame of women's reproductive cycle, RCH expanded reproductive health to include the life cycle of a woman from conception to menopause. Thus her health is crucial to overall development. There is also a section on empowerment of women and removing the discrimination surrounding the girl child "to increase public awareness of the value of the girl child and to strengthen her self-esteem" (p. 10). The participants at the ICPD suggested that governments develop an integrated approach to meet the special health, educational, and social needs of girls and young women and strictly enforce laws to ensure that marriage is between free and fully consenting adults.

The ICPD (UNFPA, 1994) is explicit about the role of bilateral and multilateral funding for reproductive health, unlike the HFA, which advocated self-reliance and self-determination. The ICPD encouraged the involvement of the private sector in the promotion of RCH without addressing the issues of ethics, profit, special interests, debt burden, and exploitation. The ramifications of bilateral and multilateral funding and the continued burden that they exert on the recipient countries and the citizens who are already caught in the vicious cycle of poverty are ignored. Thus in the Costa Rica example, Morgan (1990) noted:

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[14] During an interview, a medical officer (MOm) noted that the hierarchy in decision making affects the woman's decisions concerning family planning. See Neelsen (1991).

[15] The perceptions of rights are not as simple as they may appear. The right to do something 'right' is influenced by the sociocultural values of the individual.

> When international aid agencies began to promote community participation in health, they ignored a long history of non-participatory rural health programmes, much as they overlooked the fact that rural communities had always been involved in their own health care through indigenous healing and health enhancing behaviour. (p. 218)

The involvement of NGOs in health work poses another problem. Although their involvement would ensure that health care is accessible to many, at the same time their presence in the health care delivery would ensure that the government relinquished its social responsibility. By distributing the health work, the government can distance itself when and if there are inequities and 'offload' the burden onto its citizens (especially onto women, who bear the hidden costs of caring for family members at home). In addition, there are questions about how the national standards for health services should be maintained, who should do it, and the 'piecemeal' effect of health delivery.

Conclusion

The vision of HFA remains pertinent today, more so with the advent of increased global trade and health expenditure and movement of people. The multisectoral co-operation, which is the cornerstone for HFA, was reaffirmed at an international meeting in 1997 in Halifax, Canada (Antezana, Chollat-Traquet, & Yach, 1998). During this meeting participants emphasised the need to make health central to all development work because the long-term goal is to bring about sustainable development and to eradicate poverty (Antezana et al., 1998). Therefore good health is more than absence of disease. It was noted that "scientists, structures and databases that focus wholly or largely on disease or injury outcomes, or on the major determinants of those outcomes, will become increasingly less relevant for informing health programmes and policies" (Lerer, Lopez, Kjellstrom, & Yach, 1998, p. 18).

Good health is a "recognition that the enjoyment of highest attainable standard of health is a fundamental human right" (Antezana et al., 1998, p. 3). In a series of background papers presented by WHO, socioeconomic determinants of health were recognised as critical inputs towards attaining and promoting good health. Unlike the original HFA framework, the authors of the background papers called for greater gender mainstreaming (incorporating gender perspectives in all government policies), better human resource development, and increased opportunities for female participation and for improved social capital[16] (Adams & Hirschfield, 1998; Lerer et al., 1998). Lerer et al. noted that the "lack of gender sensitive variables for socioeconomic and health indicators makes it difficult to accurately quantify the burden of disease carried by girls and women" (p. 10). In addition, Adams and Hirschfield contended that "human resources development is one of the most important elements in health systems development" (p. 30). Taken together, these observations have far-reaching implications for *Dai*s and for the Gujarat government to map out its human resource development to meet the health needs of the population. Again, these authors noted that

> there has been insufficient analysis of the underlying issues and the potential impact of HR [human resource] policy decisions on the health policy of the country in question or that of other countries. This has led to governments becoming increasingly aware that they must take more comprehensive approaches to human resources for health development, rather than, as in the past, pursuing initiatives aimed at correcting specific aspects of the HRH imbalances. . . . One of the central challenges in the 21st century will be to define the relevant concept of human resources for health development and to engage new actors such as universities, research communities, and consumers in the definition of the services to be provided, the identification of providers and how best to support them in meeting the needs of the communities. (pp. 28-31)

The papers also reaffirmed the centrality of community participation and the involvement of informal workers in the current review of HFA (Adams & Hirschfield, 1998; Lerer et al., 1998). However, there is still a gap between the formulation of the above concepts and their operationalisation. Questions such as what is the difference between community participation and work, who are the informal health workers, and how will their remuneration be formulated are not addressed. In fact, Navarro's (1984) criticism that the apolitical nature of community participation marginalises individuals and hides their contributions remains valid even in this recent review of HFA. To this end, my research using multiple perceptions on *Dai*s' work could fill in the gap. It shows how one group of women health workers conceptualise their work both at the personal and community levels and the effect on their health. *Dai*s' work provides a unique case because it is feminised work, performed by women who are marginal, at the grassroots level.

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[16] Social capital includes adequate nutrition, education, housing, equitable policies for equal opportunity for every citizen, incorporating ethical principles when developing infrastructure, human rights and recreational facilities.

Data from my fieldwork about *Dais*' work can be used to compare whether the ideals of the theoretical frameworks, when implemented, approximate *Dais*' reality.

My evaluation of the three frameworks shows that even when terms, programmes, and policies appear equitable, they must be viewed critically because they could adversely affect individuals once they are implemented. Certainly the frameworks encourage health to be viewed holistically, moving away from the narrow interpretation (absence of disease) to using more global socioeconomic perspectives. This move fits well because there is increasing awareness that women's health and the burden of disease differ from men's. Health initiatives that address women's well-being must take into account their social, economic, and political status, especially in a stratified society. In most societies women assume the triple burden of caring for their families, performing household duties, and earning income.

Health for All (HFA; WHO, 1978), the *Ottawa Charter* (1986), and *Reproductive and Child Health* (RCH; UNFPA, 1994) frameworks are useful because they legitimise grassroots initiatives. The outcome of this legitimisation is that individuals who otherwise may not be considered as key players in health promotion are now perceived as important contributors. The frameworks also make the link between individuals' health status and national and international events. This is important because policies and programmes targeting vulnerable groups have links to larger funding and political networks and to national interests. RCH goes one step further and connects women's well-being (using a life-cycle approach) to social structures and social capital. Economic opportunities, gender mainstreaming, and political empowerment are key variables to promote women's well-being. The literature using socioeconomic determinants of health (SEH), on the other hand, showed that poverty is the root cause of ill health. Indeed this link was noted by Lerer et al. (1998) in their background paper, *Health for All: Analysing Health Status and Determinants*. They observed:

> Poverty remains perhaps, the most important cause of ill-health. Economic advancement often does little to help poor and vulnerable groups. The poorest countries are forced to use scarce resources to deal with the consequences of poverty, rather than its causes. The size of the income gap between the richest and the poorest in a community, is a good indicator of health status. The contention that the disparity between rich and poor is a major health determinant is supported by data showing that countries with high social expenditure have good health status. As long as social inequalities are large, inequalities in health will persist. (p. 16)

Because poverty is both a cause and a consequence of ill health, and in most cases women are the poorest of the poor, I set out to explore *Dai*s' work. The goal was to increase our understanding of whether and how employment promotes women's well-being. It would be interesting to observe whether employment presents opportunities to women and whether this is dependent on the type of work performed.

CHAPTER 3

GUJARAT HEALTH CARE SYSTEM

Introduction

This chapter is about Gujarat's health care system and its health work. It begins with a discussion of how *Dai*s' work is influenced by health policies and frameworks formulated at national and international levels. The integration of *Health for All* (HFA; WHO, 1978) and *Reproductive and Child Health* (RCH; UNFPA, 1994) frameworks into India's and Gujarat's health care systems and the evolution of the family welfare programmes are also discussed. Background information about Gujarat such as its history, health care structure (rural and urban), demographic data, and basic health indicators are included to give a better perspective about its various health initiatives and health status of its citizens. A brief history chronicling *Dai*s' training is also included. The chapter concludes by drawing on the lessons learned about *Dai*s within the HFA and their usefulness in the implementation of RCH framework.

Multiple Stakeholders and *Dai*s

*Dai*s contribute at the grassroots level, but they are affected by policies created at the international and national levels. At the international level, organisations such as WHO, UNFPA, UNICEF, the World Bank, and foreign donors exert their influence indirectly through their technical advice and financial aid to India. For example, although WHO positions itself as a provider of technical advice, the organisation is influential in persuading individual countries to adopt strategies that it presents to them either through its various research and position papers or conferences. On the other hand, UNFPA, UNICEF, and the World Bank provide both technical advice and financial aid to countries (including India) to assist them in their health and economic initiatives (UNICEF, 1999; World Bank, 1995, 1997). The goal of these agencies is to promote sustainable development, alleviate poverty, and empower. In addition, the linkages that international agencies establish with the Government of India (GOI) have enabled them to form partnerships with the local non-governmental organisations (NGOs). The 'collaborative' links with NGOs provide them with an additional point of entry into the grassroots arena, further exerting their influence and integrating their perspectives. Two observations emerge here. First, *Dais*' grassroots work is closely connected to the macro-level health policies through technical and financial assistance. Second, in spite of the suggested bottom-up approach, health work continues to be a top-down initiative.

The partnerships with NGOs give the impression to outsiders that the GOI and the international agencies receive the direction for their interventions from local feedback. This impression is misleading because the NGOs rely on the funds that the GOI and the international agencies disburse. NGOs are bound by the rules and regulations stipulated by funding and government agencies. Taken together, the involvement of multiple stakeholders in health work leads to multiple expectations placed on the *Dais*. They are subject to decisions into which they may not have input, further emphasising their marginality. In addition, the expectations place the burden of providing accessible and appropriate health care squarely on the *Dais*. This is achieved through the implementation of the RCH and HFA frameworks, which call for either *Dais*' direct involvement or indirect involvement through improving women's income and work security.

The Beginning of a Decentralised Health Care Structure in India

Soon after India's independence in 1947, the central government embarked on a programme in 1952 to establish Primary Health Centres (PHCs) in each Community Development Block with a population between 60,000 and 80,000. This programme was known as the Community Development Programme (MOHFW, 1992-1998). Afterwards, the health organisation and infrastructure in India underwent various changes based on the reviews of a number of Expert Committees set up by the central government (MOHFW, 1992-1998).

The implementation of WHO's HFA framework was discussed during India's Sixth Five-Year Plan (1980-85). A critical review was made of the various health approaches adopted in the previous Five-Year Plans. The HFA provided the ideal framework for India to utilise its vast human resources and to reach out to those who were unable to access health care. After signing the Alma-Ata Health for All 2000, the Indian Parliament adopted the National Health Policy in 1983 to incorporate and consolidate its health care delivery to further include the following features of HFA such as appropriate technology, affordability, availability, accessibility, and acceptability during its Seventh Five-Year Plan (1985-1990) (MOHFW, 1992-1998). The implementation of the HFA was possible because a decentralised health structure already existed in India. The goal was to develop the rural health infrastructure to provide primary health care services to 74% of the rural population who did not have access to health care (MOHFW, 1992-1998). The Ministry of Health and Family Welfare in 1997 noted:

> The delivery of Primary Health Care is the foundation of [the] rural health care system and forms an integral part of the national health care system. For developing vast human resources of the country, accelerating the socio-economic development and attaining improved quality of life, Primary Health Care is accepted as one of the main instruments of action. *Primary Health Care is essential health care made universally accessible to individuals and acceptable to them through their full participation and at a cost the community and the country can afford.* (p. 2)

The Ministry (MOHFW, 1992-1998) observed that *Dai*s conduct a large majority of deliveries in the rural areas, and therefore the goal of the Ministry was to train them. The objective was to involve *Dai*s in registration of pregnant women for prenatal care, immunisation, and the propagation of the small family (two-child) norm. There was a widespread belief at policy level that India's high population growth negated its economic advances (MOHFW, 1996-1997). The reproductive health policy was geared towards a target-based approach, and women were the main focus of the two-child norm.

The Evolution of National Health and Family Welfare Programmes and Policies

In 1951 India initiated the National Family Planning services using a clinical approach that set targets for each year. The objective was to "raise the living standard of its people, and to open up for them new opportunities for a richer and more varied life" (MOHFW, 1998, p. 1). In 1952, based on this objective, the Government of India began establishing the infrastructures to deliver primary health care and family planning services to its population in the rural areas (discussed above). The goal of the family planning was to promote responsible parenthood -- a two-child family regardless of the sex of the children through voluntary use of contraceptives (National Family Health Survey [NFHS], 1993).

This was followed by an extension education approach introduced in 1963-64 in which various media were used to inform the public of the benefits of a small family and the introduction of the reward system. Between 1970 and 1973 mass vasectomy camps were organised where forced vasectomies were performed. There was political fallout from this that led to the defeat of Indira Gandhi's government (the long-term impact of these forced vasectomies on the family planning is unknown). Between 1974 and 1977 the National Family Planning services was renamed Family Welfare programme, making a move towards a more integrated health approach that included nutrition, sanitation, primary health disease, and education of women. This also saw the introduction of another programme known as the Integrated Child Development Services (ICDS) in 1975.[17] The goal of the ICDS was to improve the nutrition and the health of children below the ages of six and those of pregnant and lactating women.

The Maternal and Child Health (MCH) programme was introduced during 1977-78 to focus on improving the health of mothers and young children through prevention and treatment of major diseases. At the same time Oral Rehydration Therapy (ORT) was initiated to reduce deaths among children (0-5 years) due to diarrhoea. Another programme known as the Expanded Programme on Immunisation (EPI) began in 1978 with the objective of providing free basic vaccinations to all eligible children and expectant mothers. The EPI was later renamed the Universal Immunisation Programme (UIP) in 1985-86. In 1992-93 all of these programmes were integrated into the Child Survival and Safe Motherhood (CSSM) programme during India's Eighth Five-Year Plan.

In 1997 the target approach that had dominated most of India's family planning work saw a shift. The Government of India is currently trying to move away from a target-oriented to a target-free approach following the Cairo ICPD Conference in 1994. At this conference, the approach known as RCH was formulated. The basic premise of RCH is that a woman's health begins at birth and continues until she is menopausal. Her reproductive health is just one aspect of her overall health. The RCH incorporates all the components of the Child Survival and Safe Motherhood (CSSM) and additional components such as Sexually Transmitted Diseases (STDs) and HIV. RCH has further identified the importance of active male participation and gender sensitisation in the promotion of women's and child health. India instituted the RCH programme in 1997. However, during the tenure of my fieldwork in 1999, intensive training of various health care workers was still being carried out in many parts of the country, including Gujarat. The purpose of the training was to sensitise them to approach health as a holistic rather than a clinical phenomenon. The apparent 'change' is that the 'target' should come from the community's needs rather than from the top down (GOI, 1997a, 1997b, 1997c). Under the RCH programme, health care workers have to tailor the focus of their work based on the needs of the communities.

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[17] Integrated Child Development Services (ICDS) is a comprehensive programme of the GOI for early childhood development. The objective of the ICDS is to ensure child survival. It thus focusses on health, nutrition, and education and includes services such as supplementary nutrition, immunisation, referrals, and health check-ups. Health and nutrition education is provided for children under the age of six and for expectant and nursing mothers. The GOG has the Special Nutrition Programme, the Wheat-Based Nutrition Programme, the Adolescent Girls Scheme, the *Udisha* Programme (training), and the Micronutrient programme (GOG, 2000).

The RCH framework advocates good health as having full employment and income, skills development, and housing; addressing gender bias; and promoting gender equity, education, housing, clean water, safe environment, and sustainable development. All of these have widespread ramifications for the population in Gujarat and the government to reorient its health policies.

Health is the obligation of the state governments, although the guiding health policies are under the jurisdiction of the central government. It is up to the state governments to tailor the main policies according to the needs of their populations. Thus the state and central governments jointly share the health responsibilities. Because of the autonomy of the state governments, there is wide variation in the way that health care is administered in India. In Gujarat, as in many parts of India, health care delivery comes under the jurisdiction of other ministries, following the multisectoral approach of WHO's HFA. Ministries and departments that promote health are Health and Family Welfare, Human Resource Development, Women and Child Development, Welfare, Food and Civil Supplies, Agriculture, Rural Development, Urban Development and Housing, Environment, Railways and Communications, Energy, and Labour (Reddy & Selvaraju; as cited in Mahadevia, 1999).

Accessible Health Care: Challenges for the Gujarat Government

One of the challenges that the Gujarat government faces is how to allocate its limited health resources equitably so that basic health is accessible to everyone in both urban and rural areas. The second challenge is how to ensure that health services keep up with the increasing demands of the population. The third challenge that it faces is to ensure that other social and economic opportunities are available to the population to promote their health. In Gujarat this issue is further complicated because in metropolises with populations of over 500,000, health and other needs (education, transportation, security, water and housing) come under the purview of a civic body known as the Municipal Corporation and not the state government.[18] Because the health structures of urban and rural Gujarat differ, the government faces the task of ensuring that the budget allocation meets the health needs of the entire population, especially in the context of rural-urban migration. Various NGOs such as SEWA intersect here to assist the government to meet the shortfall in health provision. As discussed previously in Chapter 2, NGOs should neither assume the role of the government nor shoulder the task of providing basic needs on a long-term basis. Their interventions should be short-term until the government is able to meet the health needs of the population.

Gujarat State

Brief History

During the British Raj, Gujarat was divided into British-ruled territories and the various princely states. In 1947 when India achieved its independence, the various princely states were merged into the Indian Union, and the Gujarati-speaking populace was brought under the administrative control of the Bombay State. In 1960 the states of Maharashtra and Gujarat were carved out of the bilingual Bombay State. The present Gujarat state has therefore undergone three administrative stages: the integration of states and estates in the British District in 1948-49, the reorganisation of states and the formation of a bilingual Bombay State in 1956, and the bifurcation of the Bombay State in 1960. The present Gujarat State came into being on May 1, 1960 (Bhatt, 1998; GOI, 1989, 1991; NFHS, 1993).

People, Culture, Religion, and Language

People in Gujarat adhere to a variety of religions, including Islam, Buddhism, Jainism, Hinduism, Christianity, and Zoroastrianism. The varied languages spoken in Gujarat reflect its rich histories and the migration of various individuals. They include Gujarati, Urdu, Hindi, Parsi, Sindhi, Telegu, Tamil, English, and Marathi.

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[18] This does not mean that the state government ignores the needs of the urban population. The state government does allocate certain funds in addition to the corporation managing its own funds through taxation and other funding from various sources.

Geographical Features

Gujarat is situated on the west coast of India. It shares its borders with Rajasthan to the east, with Madhya Pradesh to the southeast, Pakistan to the north, and Maharashtra to the south. Gujarat has an extensive coastline of approximately 1600 km on the Arabian Sea (Maps 1 and 2).

The Tropic of Cancer passes through the northern border of Gujarat, and because of its long coastline, peninsular Gujarat experiences wide climatic variations and temperatures that range from 45° Celsius in the summer around May to 0° Celsius during winter. The winter occurs from November to February, and the temperature begins to rise again in March onwards.

Gujarat lies in the monsoon belt. The monsoon season usually begins in the month of June and continues until October. It provides a welcome relief from the heat. Rainfall is variable in the state, ranging from 33 cm in Kutch to 152 cm in parts of Saurashtra. The Dangs region has the highest rainfall at 190 cm. Despite massive amounts of rainfall, the state continues to experience a water shortage. Certain districts such as Mehsana, Kutch, Surendrenagar, Banaskantha, Panch Mahals, and Ahmedabad are known as water-scarce regions.

Area and Population

Table 1 gives the demographic data on Gujarat. Gujarat has an area of 187,091 sq. km; this represents 6% of India's total land mass. Gujarat's population is 50 million, representing 5% of India's total population of 1 billion (India Census, GOI, 2001).[19] Gujarat's decadal growth during 1991-2001 was 22.48%, compared to India's 21.34%. The population density in Gujarat is 258 per sq. km compared to 324 persons per sq. km for all of India; this density varies within the state (India Census, GOI, 2001). For example, in Kutch, it is 33 persons per sq. km and in Gandhinagar it is 616 persons per sq. km. The plains of Gujarat are the most densely populated regions. 62% of Gujarat's population lives in rural areas compared to 72% in India (India Census, GOI, 2001). The state's urban metropolises are Ahmedabad, Gandhinagar, Rajkot, Surat, and Varodora. The NFHS (1993) noted that there had been an increase of 6% in the urban population

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[19] India conducted its sixth census in 2001. Demographic data are available on its web site at http://www.censusindia.net. However, the work is in progress. Where data for 2001 are unavailable, I use the information from the 1991 census, which will be indicated clearly in the text. Certain health and demographic data for Gujarat are not available because enumerators were unable to conduct the census because of the massive earthquake that Gujarat experienced on January 26, 2001.

Table 1

Demographic Indicators[20]

Basic Indicators		Gujarat	India
Total population 2001		50.59 m	1.02 billion
Decadal growth (%) 1991-2001		22.48	21.34
Land area (sq. km)		187,091	3,166,414
Density (per sq. km) 2001		258	324
Urban population (m) 2001		18.90	285.4
Urban population (%) 2001		37%	28%
Rural population (m) 2001		31.70	741.7
Rural population (%) 2001		62%	72%
Population (0-14 yrs.) (%)	1981	38.8	39.6
	1991	34.6	36.3
65 yrs. + (%)	1981	3.5	3.8
	1991	3.6	3.8
Scheduled castes[21]	1991	7.4	16.7
Scheduled tribes[22]		14.9	8.0
Female:male ratio (per 1,000)	2001	921	933
Literacy: male (%)	2001	76.47	75.85
female (%)	2001	55.61	54.10

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[20] Data for these demographic indicators are taken from NHFS (1993); Hirway and Mahadevia (1999); Mahadevia (1999); GOG, 1996-97; GOG, 1998-99; Census of India (GOI, 2001) web page at http://www.censusindia.net.

[21] The Government of India (GOI) has identified certain castes as socially and economically backward, and, recognising the need to protect them from social injustice and all forms of exploitation, the Constitution of India has conferred on them special protection. The term *Scheduled Caste* was used for these caste groups for the first time in India in the Government of India Act of 1935 (Office of Registrar General and Census Commissioner, 1984a). The list of scheduled castes used in the 1991 census was based on the Scheduled Castes and Scheduled Tribes Orders (amendment) Act of 1976 (Central Act 108 of 1976). Scheduled Caste refers to such castes, races, or tribes, or parts of groups within such castes, races, or tribes as are declared to be Scheduled Castes by the President of India by public notification (NHFS, 1993).

[22] Scheduled tribes refer to such tribes or tribal communities or parts of groups within such tribes or tribal communities as are declared to be scheduled tribes by the President of India by public notification (Office of the Registrar General and Census Commissioner, 1984a; as cited in NHFS, 1993).

between 1971 and 1991. Ahmedabad is the seventh largest city in India. The capital of Gujarat is Gandhinagar, where various government ministries are located. Gujarat has 19 districts,[23] and each district is subdivided into *talukas* (subdistricts); each subdistrict is further subdivided into a number of villages (Figure 1). This decentralisation occurred in 1963. A democratically elected body known as the *Panchayati Raj* governs each division (Figure 1).

In 2001 Gujarat's female to male sex ratio was 921 to 1,000 males, compared to India's 933.[24] The percentage of the child population (0-14 years) to the total population is lower in Gujarat compared to India, reflecting a potential trend towards a lowered birth rate and a decline in fertility. Gujarat's over-65 population, however, is 4%, which is comparable to India's. Scheduled Castes and Tribes in Gujarat comprise 7% and 15% of the total population, respectively. In India these figures are 17% and 8%, respectively.

Addressing Health: Using a Multisectoral Approach in Gujarat

In their *Gujarat Human Development Report* Hirway and Mahadevia (1999) noted that environmental health is emerging as an area of concern. This is related to the degradation of the environment due to uneven and rapid industrialisation that has led to deforestation, desertification, and soil erosion. According to the authors, all these have adversely affected Gujarat's human development and population health. Environmental degradation and unsustainable development have caused mass migration, illiteracy, poverty, and indebtedness. The authors suggested that the government pursue "environment-friendly" policies that would create employment, promote sustainable development, decrease mass migrations, and control pollution. One such policy is good water management, which supports judicious use of water to promote sustainable agriculture practices. Others include social forestation (for fuel and fodder), reforestation, and watershed planning, which would create long-term employment, generate income, prevent environmental degradation, and check mass rural-urban migration. All of these would improve the lives of people, especially women and girls, who are entrusted with the tasks

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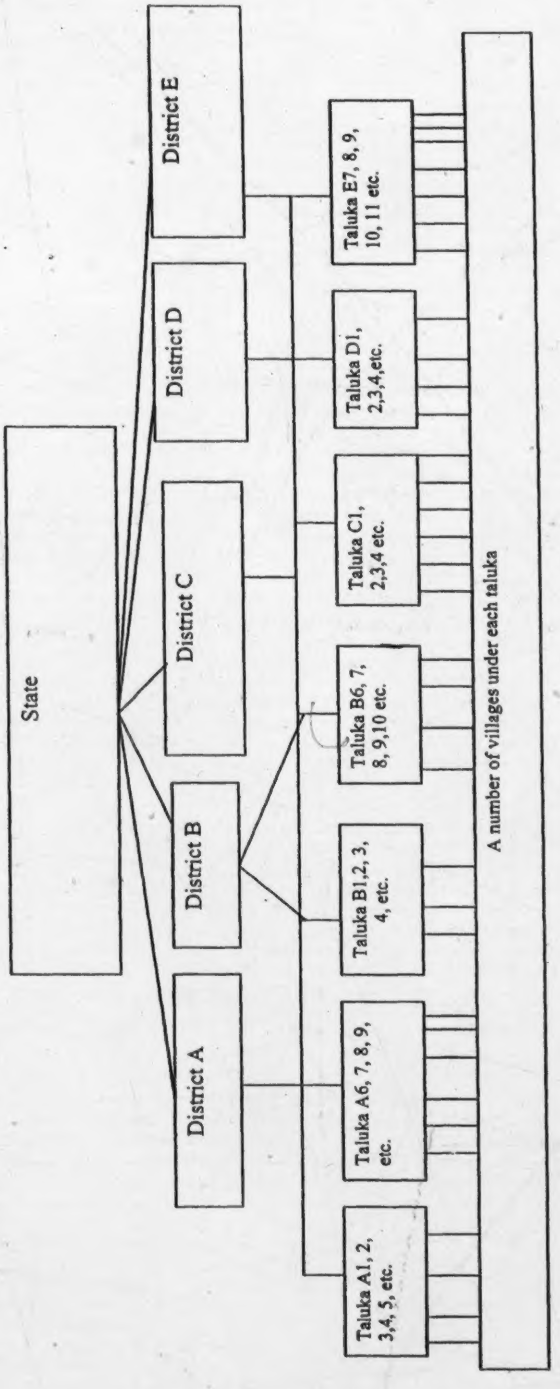
[23] In April 1999 six more districts were created. However, data in government publications and the Gujarat Human Development Report (1999) continue to allude to the 19 districts.

[24] Two articles in the *Times of India* (December 24 and 27, 2001) entitled "Female Foetocide Leads to a Lopsided Sex Ratio" and "Female Foetocide Is Bio-terrorism" indicated that the practice of female foetocide is still prevalent in Gujarat. The results of the 2001 census show that the female to male ratio has worsened. In 1991 the ratio was 934 females to 1,000 males.


State
District A
District B
District C
District D
District E
Taluka A1, 2, 3,4, 5, etc.
Taluka A6, 7, 8, 9, etc.
Taluka B1,2, 3, 4, etc.
Taluka B6, 7, 8, 9,10 etc.
Taluka C1, 2,3,4 etc.
Taluka D1, 2,3,4,etc.
Taluka E7, 8, 9, 10, 11 etc.
A number of villages under each taluka

An independent body known as the *Panchayat* governs each level. Therefore at the district level, it is the District *Panchayat*, at the *taluka*, it is *Taluka Panchayat*, and each village has its own *Panchayat*

Figure 1. Geographical organisation: State, district, *taluka*, and villages (fieldwork data, 1999-2000).

of collecting fuel and fetching water, usually walking long distances (Hirway & Mahadevia, 1999). Environmental degradation therefore impacts health at multiple levels. The immediate consequences are poverty and migration, but the ramifications of these are long term, such as loss of opportunities because of lack of schooling, low self-worth, adverse childhood development (physical and mental), depletion of nonrenewable resources, ill health due to pollution, diseases related to malnutrition, mortality, and morbidity.

Adequate income and year-round employment would therefore reduce mass migration to urban areas. Hirway and Mahadevia (1999) indicated that although Gujarat's economy is expanding, its prosperity comes at the expense of the environment and the health of the citizens. It also masks the high rate of un/underemployment. In the rural area this has led to displacement through migration. In the urban areas the closure of certain industries has led to informalisation of labour. Women are more affected when an industry becomes modernised. They are either retrenched or replaced by machines (Hirway & Mahadevia, 1999). Women form the bulk of marginal and self-employed workers. SEWA's research shows that women are often engaged in low-paid work and work long hours. One reason for women's low earnings is their low educational level and skills or illiteracy. Low income and lack of employment security lead to poverty, poor nutrition, and anxiety. Structural inequities further prevent women from either learning about opportunities or accessing them.

Hirway and Mahadevia (1999) observed that mass migration often leads to ill health. Individuals are employed in low-paid work, live in unsanitary conditions, lack clean water, do not have adequate nutrition, and lack proper housing. Often they are found living in areas that are polluted from industrial run-off. The lack of clean water gives rise to various water-borne diseases. Unhygienic living conditions and inadequate nutrition lead to high infant and child mortality. Migration also disrupts children's education, because they have to follow their parents in search of work. Girls experience a greater burden from migration because they assume the caregiver role while their parents work (Hirway & Mahadevia, 1999), and this affects their schooling.

Low nutritional status and illiteracy give rise to ill health. These determinants of health are interrelated, and deficiencies in one area affect the other. Despite the increase in the literacy rates in Gujarat, there continues to be a discrepancy between males and females and among the tribal populations. The gap between males and females is higher in the rural areas than in the urban region. The data show that girls drop out of school earlier than boys. One reason is the gender bias against females in a patriarchal society. From a young age, a girl is taught that her primary role is to be a homemaker and rear children. Based on this, many parents do not encourage their daughters to continue their schooling at a higher level. Poverty and migration further compound the gendered division of labour. In addition, women are expected to "marry up"; that is, to marry a man with more education (Hirway & Mahadevia, 1999, p. 184). Apart from the social reasons, the lack of educational facilities in the villages affects the dropout rate because parents are reluctant to send their daughters out of the community for schooling (Hirway & Mahadevia, 1999). Women and girls in tribal populations suffer even more because of double marginalisation; that is, the lack of educational facilities and effect of social norms.

Various studies show that female education has a positive impact on their health and on their children. Jejeebhoy (1995) noted that although the relationship is linear in developed nations, in gender-stratified societies and 'developing' countries the relationship is not straightforward. In these societies there appears to be an educational threshold where education has minimal impact. It is after the threshold is crossed that the positive effects on health are obvious (formal employment and fertility). In addition, in gender-stratified societies it is a sign of prestige for the better educated from higher-income households to withdraw from the workforce (Hirway & Mahadevia, 1999; Jejeebhoy, 1995). However, despite these qualifiers, education is key to women's health because it builds their capacities to initiate changes in their lives. One such change affects the relationship between nutrition level and gender. Jejeebhoy noted that women who are educated control the internal distribution of food. They neither neglect their own needs nor favour one sex over the other.

Malnutrition has deleterious effects on children's development. The data of the National Family Health Survey (NFHS) indicate that malnutrition is the cause of many physical and mental disabilities. Children who suffer from extreme malnutrition develop diseases such as kwashiorkor, marasmus, anaemia, endemic goitre, and xerophthalmia (severe Vitamin A deficiency) (NFHS, 1993). Malnutrition during childhood has lifelong effects, which was noted in Canada's National Forum on Health (NFH, 1997). The NFH also observed that early child development has a strong relationship to the chronic diseases during adulthood. Children and women in Gujarat continue to experience various degrees of malnutrition. The Government of Gujarat (GOG) continues to operate the Mid-Day Meal Programme that began in 1984 to ensure that children attending school receive proper and adequate nutrition. The programme was modified to provide 10 kilograms of uncooked cereals for each child. However, in 1992 it reverted back to the cooked meal scheme to ensure that each child received at least one cooked meal a day (GOG, 1998-99; Hirway & Mahadevia, 1999).

Health workers distribute free iron and folic acid tablets to women who are pregnant. According to Hirway and Mahadevia (1999), anaemia is one of the major consequences of ill health from malnutrition in Gujarati women. This state is worsened when women become pregnant and experience multiple births; it is one of the major contributing factors to maternal mortality. In Gujarat malnutrition is the result of gender bias, income insecurity, poverty, and migration.

Gujarat Health Care System

Health Structure

Gujarat's health care system is decentralised. Health is administered based on a three-tiered system that includes the state, district, and village *Panchayats* (effective since 1963). The goal of the *Panchayati Raj* system was to encourage grassroots participation to promote primary health care, including the planning and the implementation of programmes and services; however, due to partisan politics, the ideals of *Panchayati Raj* are sometimes not realised. The health care structure differs in urban and rural areas (Figures 2, 3, and 4, respectively). The health care services in Gujarat are divided into two categories: health services and medical services (Dr. T. D. Gandhi, personal communication, May 1999).[25] Rural health comes under the auspices of the health department, and urban health and hospitals are under the medical services (Ahmedabad City's health and civic services are managed by the Ahmedabad Municipal Corporation [AMC]; Figure 2). Although the health care system differs in rural and urban areas, the underlying objectives of accessibility and affordability operate in both so that the population has access to

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[25] Dr. T.D. Gandhi is a medical doctor who is actively involved in volunteer work. He was a former Additional Director of Health and Family Welfare of Gujarat. He is retired now.

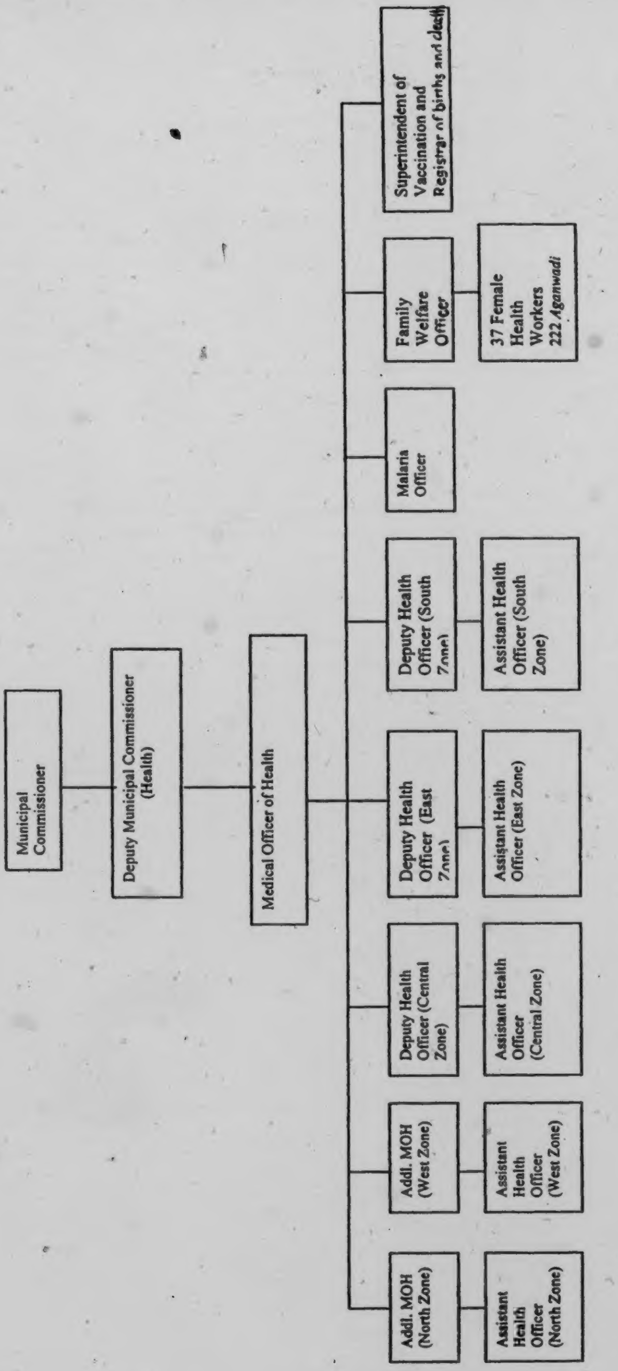

Municipal Commissioner
Deputy Municipal Commissioner (Health)
Medical Officer of Health
Addl. MOH (North Zone)
Assistant Health Officer (North Zone)
Addl. MOH (West Zone)
Assistant Health Officer (West Zone)
Deputy Health Officer (Central Zone)
Assistant Health Officer (Central Zone)
Deputy Health Officer (East Zone)
Assistant Health Officer (East Zone)
Deputy Health Officer (South Zone)
Assistant Health Officer (South Zone)
Malaria Officer
Family Welfare Officer
37 Female Health Workers 222 *Aganwadi*
Superintendent of Vaccination and Registrar of births and death

Figure 2. Organisational structure of urban health department of Ahmedabad Municipal Corporation (AMC, 1999).

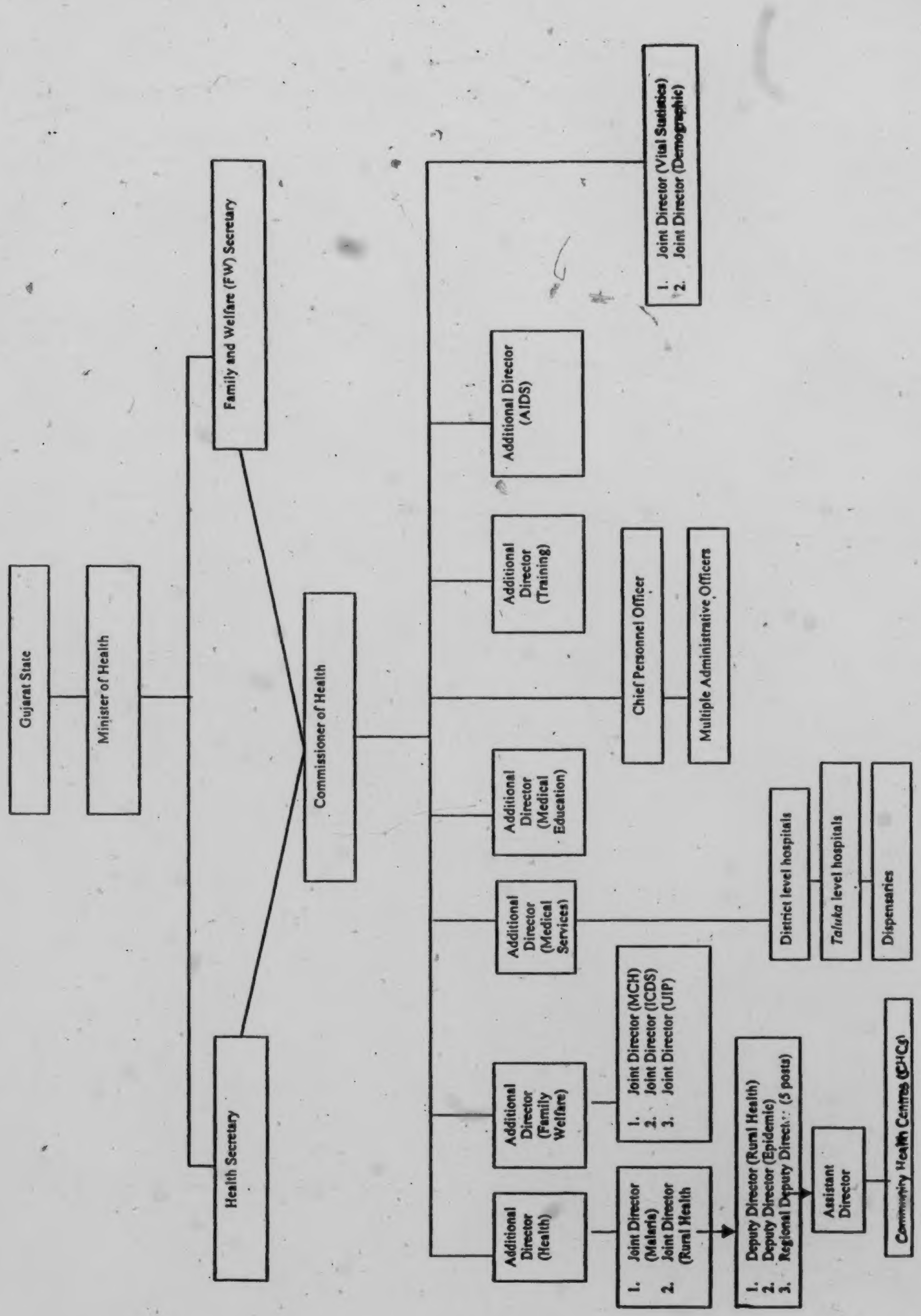
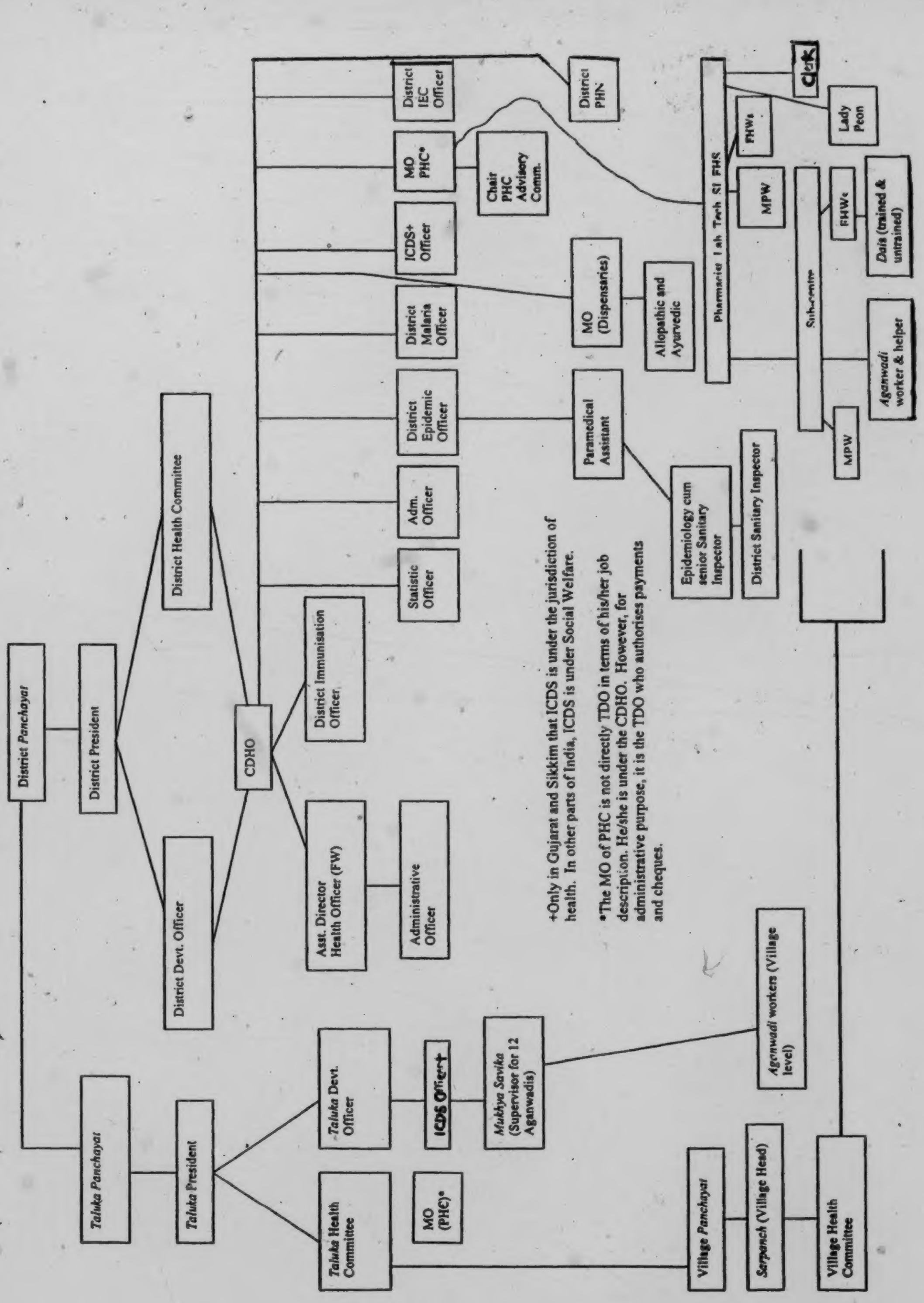

Gujarat State
Minister of Health
Family and Welfare (FW) Secretary
Health Secretary
Commissioner of Health
Additional Director (Health)
Additional Director (Family Welfare)
Additional Director (Medical Services)
Additional Director (Medical Education)
Chief Personnel Officer
Multiple Administrative Officers
Additional Director (Training)
Additional Director (AIDS)
1. Joint Director (Vital Statistics)
2. Joint Director (Demographic)
1. Joint Director (Malaria)
2. Joint Director (Rural Health
1. Joint Director (MCH)
2. Joint Director (ICDS)
3. Joint Director (UIP)
District level hospitals
Taluka level hospitals
Dispensaries
1. Deputy Director (Rural Health)
2. Deputy Director (Epidemic)
3. Regional Deputy Director (5 posts)
Assistant Director
Community Health Centres (CHCs)

Figure 3. Gujarat rural health care structure (Gandhi, 1999).


District *Panchayat*
District President
District Health Committee
District Devt. Officer
CDHO
District Immunisation Officer
Asst. Director Health Officer (FW)
Administrative Officer
Statistic Officer
Adm. Officer
District Epidemic Officer
District Malaria Officer
ICDS+ Officer
MO PHC*
District IEC Officer
District PHN
Chair PHC Advisory Comm.
MO (Dispensaries)
Allopathic and Ayurvedic
Paramedical Assistant
Epidemiology cum senior Sanitary Inspector
District Sanitary Inspector
Pharmacist Lab Tech SI FHS
FHWs
MPW
Clerk
Lady Peon
Sub-centre
FHWs
Dais (trained & untrained)
Aganwadi worker & helper
MPW
Taluka Panchayat
Taluka President
Taluka Devt. Officer
Taluka Health Committee
MO (PHC)*
ICDS Officer+
Mukhya Savika (Supervisor for 12 Aganwadis)
Aganwadi workers (Village level)
Village *Panchayat*
Sarpanch (Village Head)
Village Health Committee

+Only in Gujarat and Sikkim that ICDS is under the jurisdiction of health. In other parts of India, ICDS is under Social Welfare.

*The MO of PHC is not directly TDO in terms of his/her job description. He/she is under the CDHO. However, for administrative purpose, it is the TDO who authorises payments and cheques.

Figure 4. District, *taluka*, and village health care structure (rural) (Gandhi, 1999).

health care. The Minister of Health manages the health portfolio, and the Secretaries for Health and Family Welfare assist him.[26] The Commissioner of Health, who is usually a bureaucrat trained under the Indian Administrative Service (IAS), oversees the management and the delivery of health such as family welfare services, medical services, and medical education in the state.

Urban Health Care Structure

The urban health system is divided into three levels (Figure 2); however, these are structured based on the needs of the urban population (Dr. T. D.Gandhi, personal communication, May 1999). In metropolises where the population exceeds 500,000, a body known as the Municipal Corporation takes over the responsibility for providing health care and the maintenance and functioning of the civic structures. The Municipal Corporations have their own budget and manage the taxes of their urban regions. The next level is the municipality for a population of between 100,000 and 500,000, and the *Nagar Panchayat* for a population of up to 100,000. Each of these entities is independent.

The Sanitary Inspector (SI)[27] oversees the health of the citizens and ensures the functioning of the various civic structures of the *Nagar Panchayat*s and the municipalities. The position of the SI has been upgraded to a health officer, although he/she may not be a medical officer (physician). The health officer for the Municipal Corporation is a medical doctor. The medical officer is assisted by deputies who are usually medical officers, except the malaria officer, who is a paramedic. The Municipal Corporations, municipalities, and the *Nagar Panchayat*s manage the environment, food quality, and public health measures such as the prevention and control of epidemic, sanitation, and access to health care. The Ahmedabad Municipal Corporation (AMC), however, manages a medical college in addition to the health work.

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[26] Aside from the health portfolio, Gujarat's Minister of Health manages the ministries of food and civil supplies, cow breeding, *devasthan* (environment) management, and pilgrimage.

[27] The post of the SI dates back to colonial rule. The British lived separately from the local Indian population, usually in walled compounds. In 1921 there was a cholera epidemic that killed 90% of the foreigners because they lacked immunity against the disease. The epidemic was linked to the food products (vegetables and milk) that were transported from the rural areas to the colonials. The epidemic caused a political uproar in England. To ensure that the colonists stayed in India, the post of Sanitary Inspector (SI) was created **for the indigenous Indian** population (Dr. Gandhi, personal communication, January 2000).

The AMC provides health facilities and services to the urban population, including the slum areas in and around Ahmedabad City.[28] The AMC operates and manages three general hospitals, 13 maternity hospitals, 25 dispensaries, five referral hospitals, one eye hospital, two TB clinics, four dental clinics, and four communicable disease hospitals. The hospitals and the dispensaries are well spread out geographically. In addition, there are 49 dispensaries and three general hospitals operated by the Employee State Insurance Scheme (ESIS) for industrial workers. Under the Integrated Child and Development Services (ICDS) programme, the AMC operates 200 *aganwadis* (child care centres) in the slum areas of the city. The *aganwadis* are the basic unit of the ICDS programme. According to the GOI stipulations, there should be one *aganwadi* for 1,000 people. The ICDS programme was initiated to strengthen the MCH services to ensure safe motherhood and healthy children. The ICDS provides services to pregnant and lactating mothers and basic nutrition to children between 0 and 6 years of age. The grants for the *aganwadis* come from the state government.

Aside from the health services provided by the AMC, a number of private organisations, including voluntary organisations and non-governmental organisations (NGOs), operate Trust Hospitals and clinics to provide health services to poor individuals, in addition to private hospitals and general practitioners, who practice side by side to provide health care.

Rural Health Care Structure

Just like the urban health structure, the rural health system is divided into three levels (MOHFW, 1992-98; Figures 3 and 4). The goal of a decentralised health structure was to ensure that primary health care would be accessible to people at the village level. At the same time, these facilities would be linked to emergency care and referral services. Another goal was to encourage local participation to meet local health needs. However, the absence or lack of good health infrastructure and other civic amenities has hindered the full extent of local participation with the health care workers. Furthermore, it has created a gap in the health services after work hours. This is attributed to inadequate staffing either because of unfilled vacancies or inadequate amenities that discourage staff from staying on site. *Dai*s have filled the void for delivery services. Villagers call them to attend to deliveries, because *Dai*s are accessible, affordable, and acceptable.

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[28] The AMC (1999) has submitted a proposal to the GOI for World Bank funding to structure their basic primary health facilities similar to the rural areas to provide adequate health care to the slum populations, the urban poor, and the urban population in general.

At the village level, it is the subcentre that provides the primary health care. The subcentre is the basic unit upon which other structures are built. The ideal situation envisaged by India and Gujarat governments is that the female/male health worker (FHW/MHW) would reside at or near each subcentre so that he/she would be the first person of contact for emergencies. The next level of care is the Primary Health Centre (PHC). The PHCs are built in villages that are also accessible to people from outlying areas. A full complement of PHC staff should include two physicians (biomedical and Ayurvedic), a female and a male health supervisor (FHS/MHS), FHWs/MHWs, pharmacist, malaria worker, laboratory technician, clerk, hospital assistant, driver, ophthalmic technician, and block extension educator (BEE). In many cases the ideal is not in place, and many PHCs suffer from chronic staff shortages due to unfilled vacancies and inadequate infrastructures.

In addition to staff shortages, those who work at the PHCs do not live on-site. They commute daily to work (popularly known as "up-down"). One reason for this is that basic amenities at many PHCs are either lacking or are unsuitable and, in some cases, unsafe. Some of the PHCs that I visited received water for one or two hours either twice or once a day, the electricity supply was unreliable, and there were frequent blackouts. Building structures were in disrepair and unsafe because of peeling plaster and loose concrete, exposing the scaffoldings. Water leakage occurred during the monsoon season. Furthermore, staff did not stay on-site because of the lack of other amenities such as good schools for their children, a proper sewage system, transportation (usually unreliable), streetlights (concern for personal safety), and inadequate communication facilities. Thus many of the health workers preferred to live in the cities or towns where these amenities were found. The end result is that villagers were unable to access health care after office hours. They either had to travel to larger towns or utilise the private health facilities in their villages. The expenses created an added burden for those who were poor.

At the intermediate level the Community Health Centres (CHCs), usually located at the *taluka*s (subdistrict), are affiliated with three to four PHCs.[29] The objective of the Government of

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[29] The CHCs were known as the subdistrict hospitals during the colonial period. Today all subdistrict hospitals at the *taluka* level are divided into two types: Those that are managed by the health section are known as the *CHCs*, and those that are under medical services are called *hospitals*.

India and the Government of Gujarat (GOG) is to make these CHCs the first referral units (FRUs) so that a higher level of care will be available to the rural populations quickly. Based on this infrastructure, the GOG has designated district hospitals as second referral units, and the medical colleges and the hospitals attached to these colleges will function as the third referral units. However, the implementation of the FRUs has been slow due to inadequate infrastructure and health personnel for the posts. In addition, each *taluka* has dispensaries, some of which have been upgraded to CHCs and others to PHCs. As of September 1995, there are 185 CHCs, 957 PHCs, and 7,284 subcentres (GOG, 1996-1997, 1997-1998, 1998-99).

Despite the decentralisation of health services to provide the rural population with comprehensive health care, it appears that health services after hours are either inaccessible or unavailable. One of the ways that the Gujarat government has tried to address this is to post more medical officers (MOs) to the rural areas by offering them incentives. The Gujarat government has also set aside funds to repair some of these health structures (R. M. Patel, personal communication, September 1999). The other route has been the training of the *Dais*. Although the original goal was to address the high IMR and MMR, *Dai* training has been beneficial because it provides maternity health services where they are nonexistent or inaccessible.

Health Utilisation

The health structure in rural and urban Gujarat has been set up to provide people with comprehensive health services. However, due to reasons discussed above, other individuals have entered the health care system to provide services to meet the health needs of the population. These include private clinics/hospitals, medical shops, indigenous practitioners, and *Dais*.[30] In addition to the shortfall, the prevailing attitude of biomedical personnel in public hospitals towards poor patients, perceived quality of care, and the hospital environment all play a part in how individuals utilise the health services.

Gujarat has more high-end health facilities (hospitals that can provide treatments beyond the basic primary health care services) than all of India. Gujarat ranks second after Kerala among the 15 states with respect to the number of hospitals per 100,000 population (Duggal, Nandraj, &

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[30] It is difficult to monitor to ensure that those who are providing medical care are qualified and licensed. There are individuals who after a stint in a clinic or a hospital set up their own private practice or operate their own medical shops. They are not licensed; however, due to shortage and cost, these people have found a ready market.

Vadair, 1995) and first in relation to the number of dispensaries per 100,000 population (Hirway & Mahadevia, 1999). In 1991, based on the population ratio of 100,000, the state was ranked as tenth for the number of PHCs, first for subcentres, seventh for doctors, and fifth for nurses[31] (Duggal et al., 1995).

The utilisation of the health facilities depends on the access to health personnel, the availability of medications, and the quality of health care services. Hirway and Mahadevia (1999) quoted a study done by NCAER that showed that more people use private facilities than public health services. This observation is borne out by another study done by SEWA. SEWA baseline surveys show that people tend to use private health services despite being poor because they are treated with dignity and receive services "on demand" (SEWA, 1997-98). Other reasons are trust and the perception that they are receiving quality medications.[32] The AMC (1999) observed that public hospitals are stretched to the limit, leading to long line-ups and overcrowding of wards.[33]

The urban population has a variety of health services and facilities from which to choose. These range from general hospitals to various private clinics. During the day, health workers from various maternity hospitals visit the slum areas to provide maternal and child health. However, not all the maternity hospitals are open 24 hours a day or provide all the services. Some of these operate as family planning units or post-partum units. In the rural areas, villagers in the majority of cases are unable to access the public health facilities after hours, and at times even during office hours because of the lack of staff. Rural staff are usually overworked, because they have to ensure that they not only meet their target set by the health department but also conduct and implement other health programmes and campaigns 'outside' their routine work. Each health worker is assigned to more than one village and visits these on specified days to provide maternal and child health services. Rural doctors, on the other hand, function as administrators in addition to being health care providers. Most of them are around the clinic during the morning for two to three hours, and usually their afternoons are filled with attending meetings with other health and government officials or field visits. As a result, many young doctors do not want to be posted to the rural settings. Those who are see their postings as temporary and as a rite of passage before applying for urban postings or setting up their own private practices.

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[31] The authors did not give the ratios of doctor to patients or nurse to patients for urban and rural areas.

[32] Packaging plays an important role. I observed that at one PHC, the pharmacist squeezed ointment on a piece of newspaper. Compare this with obtaining medications that are well packaged and sealed. Furthermore, there is a belief that when services and medications are free, they must be of inferior quality.

[33] Overcrowding is one of the main problems at many public hospitals in the urban areas. At one general hospital in Ahmedabad City, the post-delivery ward was so overcrowded that women were lying on the floor on mattresses in the hallways and in between the beds. According to the Head of Obstetrics and Gynaecology of a large urban hospital (personal communication, August 1999), at times two women are placed on one bed to accommodate admissions.

Hence there are a number of factors that affect effective delivery and utilisation of health services. First, the unavailability of health staff during clinic and after hours; second, the perception that government health services are of low quality and ineffective; and third, the quality of the physical infrastructure of the health services to meet the demands of the population.

Basic Health Indicators

Health indicators reflect the overall health status of the population. These indicators show trends in the impact of the health services on the population, especially the vulnerable segments. The discussion so far shows that, despite the decentralisation of health care, there is low usage and population needs continue to be unmet. In addition, the environment, nutrition, economy, and education all play a part in promoting health. This point is significant for the *Dai*s. Their work has been blamed for contributing to the high infant mortality rate (IMR) and maternal mortality rate (MMR). However, the role of the various socioeconomic determinants of health show that there are other factors that could also contribute to the IMR and MMR. In addition, the health indicators do not differentiate between the actions of the *Dai*s and other factors.

Table 2 compares the health indicators of Gujarat with the national indicators. It shows that Gujarat's overall performance is better than the national outcomes. Gujarat's crude birth rate is 25.2 per 1,000 population, crude death rate is 7.5 per 1,000, and IMR is 62 per 1,000; India's are 25.8, 8.5, and 68, respectively (India Census, GOI, 2001). When these values are compared to 1981 (34.5; 12; 116) and 1991 (27.9; 9.1; 67), Gujarat has made remarkable improvements. These improvements are due to widespread immunisations and prenatal and postnatal services made available to women in the country and to deliveries conducted by trained personnel. The NFHS (1993) noted an overall decline in the death rate in Gujarat from 1971 to 1992 is 45%. However, the survey noted that 1 in 15 children die before the age of one and 1 in 10 before the age of five. The life expectancy at birth (LEB) of both males and females in Gujarat is better than India's; however, these values are still far behind those of OECD countries. Hirway and Mahadevia

Table 2

Basic Health Indicators[34]

Basic indicators	Gujarat	India
Crude birth rate (CBR) 2000[35]	25.2 per 1,000	25.8 per 1,000
Crude death rate (CDR) 2000	7.5 per 1,000	8.5 per 1,000
a. Life expectancy at birth (LEB) male 1986-91[36]	59.5 yrs	58 yrs.[37]
female 1986-91	62 yrs	59 yrs.
b. Infant mortality rate (IMR) (2000)[38]	62 per 1,000	68 per 1,000
c. Post-neonatal mortality rate (PNMR) [%] 1993[39]	18	25.5
d. Neonatal mortality rate (NMR) 1993[40]	40.4/1000	47.1/1,000
e. Under 5 mortality (1988-92)	104/1,000 live births	105[41]
f. Child mortality 1988-92	38/1,000 live births	Data unavailable
Maternal mortality rate (MMR)	300/100,000 live births	410[42]
Total fertility rate [TFR] (no. of children/woman) (1990)	3.1	3.6
Couple protection rate (CPR) (1992)	57.0	43.5
Live births according to birth attendance (%) 1993[43]		
Institutions	15.7	15.8
Qualified medical practitioners	38.9	41.4
Unqualified medical personnel and others	45.4	42.8
Subcentres (1:5,000 pop./tribal region 1:3,000)	7,284	131,900
Primary health centres (1:30,000/1:20,000)	957	21 723
Community health centres (1:100,000 for both)	185	2390

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[34] NHFS (1993); Hirway and Mahadevia (1999); Gujarat Health Review (1995); Shariff (1999); UNDP (1999); MOHFW (1992-98); GOI (2001). According to the Registrar, complete population data would be available on the web in 2003 (Census Update, Office of Registrar, May 2002). I visited this web site on August 3, 2002.

[35] Registrar General (2001).

[36] Data relate to average over 1986-91 as estimated in by the SRS and centred at 1990 (GOG, 1998-99, pp. S88-S89).

[37] Although the 2001 census data for India are available, I continue to use the 1991 values because Gujarat's data for LEB in 2001 are unavailable. India's LEB values have shown improvement for both males and females. The LEB for males will be 63.87 years, and 66.91 years for females between 2001 and 2006 (Office of Registrar General, 2001, Provisional Population, Chapter 4, Series 1, Paper 1).

[38] Registrar General (2001).

[39] Government of Gujarat (GOG; 1995).

[40] As of September 30, 1995 (GOG, 1996-97, 1997-98, 1998-99) a-f: LEB=average number of years a newborn is expected to live under the current mortality conditions; IMR=the probability of dying before the first birthday; PNMR=the difference between infant and neonatal mortality; NMR= the probability of dying in the first month of life; U-5 mortality=the probability of dying before the fifth birthday; child mortality=the probability of dying between the first and fifth birthdays.

[41] UNICEF (2000). Data refer to 1998.

[42] UNICEF (2000). Data refer to between 1980 and 1998.

[43] As of 30th September 1995 (GOG, 1996-97, 1997-98, 1998-99). Data do not differentiate between tribal and nontribal areas.

(1999) observed that, despite the great improvements in Gujarat's health statistics, more needs to be done for women's health. The 1991 Census indicates that Gujarat's MMR is 300 per 100,000 live births, which is lower than India's (Table 2, 1998 data). However, the Government of Gujarat's goal was to reduce the MMR to 200 by 2000. The data on births show that Gujarat reports a higher percentage of institutional births and births with qualified biomedical personnel than that of India.

Anaemia is a major cause of morbidity in women and children in Gujarat. Mahadevia (1999) cited a Government of India study that showed that approximately 60% of pregnant women and 40% of children below the age of six suffer from anaemia. The causes of anaemia in young women and children are malnutrition (lack of iron-rich food) and parasitic worms in the digestive system (Mahadevia, 1999). For women, other causes of anaemia are multiple childbirths and excessive menstrual or childbirth bleeding. Anaemia is one of the major contributing factors of maternal mortality among young women (Mahadevia, 1999).

The results show that IMR and MMR continue to be high in Gujarat despite the marked improvements. There are a number of reasons for this. Women's health is affected by cultural and economic factors that are rooted in the patriarchal system. In a society where males are favoured, girls and women bear the brunt of both development and exploitation. At a young age, girls are taught that their needs are secondary to others compared to the needs of the male members of their families. These are manifested in education, nutrition, and work. The lesson is carried over once they are married. Because their needs are secondary, children and other members are allowed to eat before they do. Childbirth and housework are the other primary roles of women. Women experience societal pressure to give birth to male offspring, which often leads to multiple pregnancies. Those who are poor also shoulder the responsibility of working inside and outside the house. Early marriage and lack of opportunities due to illiteracy further compound women's limited scope to improve themselves and ameliorate the exploitation. Economic development has an adverse effect on women because they are the ones who are retrenched or replaced first. They work long hours for low pay. Hence women's health is affected in various ways beginning during their childhood. When all of these factors are taken into account, it is difficult to attribute the high IMR and MMR to *Dai*s' work.

The Overall Goals of GOI and GOG for *Dai* Training

Background

*Dai*s conduct the majority of deliveries in rural areas (Cabral et al., 1992a, 1992b, 1992c; CHETNA, 2000; GOI, 1982a, 1988, 1993a, 1993b; SIHFW, 1983, 1992, 1995, 1999; Swaminathan et al., 1986; WHO, 1982, 1995a, 1995b). Their skills and knowledge are usually passed down from generation to generation within the family. To meet the health needs of the rural population, especially maternal and child health, the GOI decided to enlist the help of the *Dai*s because they had the trust of their community members. However, they had to be trained because the assumption was that these *Dai*s were untrained. Because of this, it was assumed that *Dai*s also contributed to the high IMR and the MMR. When GOI and GOG implemented the HFA framework, the training of *Dai*s and their 'inclusion' within the formal health care system were legitimised. *Dai*s were considered to provide appropriate, accessible, and affordable care.

Table 3

Dais in Gujarat and India[44]

Basic Indicators	**Gujarat**	**India**
*Dai*s trained since inception of the scheme (1995)	32,091	628,321
Average rural population served by a trained *Dai* (1995)	843	1,000
Average no. of villages served by a trained *Dai* (1995)	0.5	0.96

Beginning in the 1950s and Into the 1960s

In 1957, during the Second Five-Year Plan, the GOI, with the assistance of UNICEF, embarked on a six-month training programme for the *Dai*s. The level of remuneration for the *Dai*s was left to the discretion of each state. However, the stipend during the training was approximately Rs. 150 per month. The *Dai*s received Rs. 2 per delivery provided that they had registered the prenatal case. The public health nurses (PHNs), lady health visitors (former title of female health supervisors), and the medical officer conducted the training. The *Dai*s received a certificate, which had the signatures of the district's PHN and the district health officer. This scheme continued during the subsequent Five-Year Plans, and during the Fourth Five-Year Plan (1969-74) it was transferred to the Department of Family Planning (National Family Planning Programme) and underwent further revision. The six-month training period was later reduced to three months, but the total number of actual training days remained only 30 working days. The duration was four hours per day twice a week (although this was left to the discretion of the trainers). The remuneration for the entire training was Rs. 300, and the *Dai*s received Rs. 2-3 for each delivery and registration. In 1967 the GOI, with the financial assistance of USAID, tried to rejuvenate the *Dai* training. In addition to ensuring safe delivery and motherhood, the *Dai*s were also instructed to motivate family-planning methods.

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[44] GOG (1995). The year 1995 indicates 'as of' and not the year of inception of the *Dai* training. The data for the inception are not indicated.

During the 1970s

In 1971 the GOI tried to boost the training scheme (the aim was to train at least 75,000 *Dai*s), but because of delays such as stipend, distribution of delivery kits, and lack of supportive services, the scheme was not successful. In 1972-73 the GOI appointed a subcommittee to study the impact of the *Dai* training scheme. As a result the training was further expanded and other components were added, such as prenatal and postnatal care of mother and child and treatment of primary health diseases. In 1978 the three-month training was reduced to one-month training. The *Dai*s received a stipend of Rs. 300 and an aluminium kit with instruments. This training was to be provided jointly by the health visitor and the ANM. The *Dai*'s responsibility was to conduct delivery using aseptic methods, recognise complicated deliveries or pregnancies, refer these women to the auxiliary nurse midwives (ANMs), and register prenatal cases. The *Dai*s were given an incentive of Rs. 3 per delivery if they followed these procedures, which was later increased to Rs. 10 (period unknown).

Training in the 1980s and 1990s

Training of *Dai*s continued throughout the 1980s, but sporadically. In 1983 the National Institute of Health and Family Welfare (NIHFW) conducted a study in 15 states. Based on its recommendations, the Gujarat SIHFW formulated a six-day training programme and a two-day refresher under a World Bank-assisted programme known as the Indian Population Project VII (IPP-VII). The SIHFW provided a six-day training programme in 1995 and a two-day refresher in 1997-98 to 10 000 active *Dai*s. The *Dai*s received Rs. 40 per day and Rs. 100 to cover their travel expenses. In 1998 Gujarat was the first state in India to issue identity cards to *Dai*s who had undergone training through the biomedical establishment. The Gujarat government increased the fee to Rs. 20 from Rs. 10 for a normal delivery and Rs. 50 for referral to a hospital or clinic in the case of a complicated delivery/pregnancy. During the same year, about 24,000 *Dai*s in Gujarat were given a two-day refresher course during the festival of *Navratri Mahotsav* (the worshipping of Mother Goddess). At the end of the two-day refresher, *Dai*s were given ID cards and *Dai* Delivery Kits (DDK). Between April 1 and 3, 1999, SEWA, with the co-operation of the state trainers, provided a refresher course to 200 SEWA *Dai*s at the Bavla Training Centre at the Bavla PHC, Ahmedabad. The goal of the GOI and the GOG was to have at least one trained *Dai* to serve a population of 1,000 in the rural areas.

Dais' Future in Gujarat

The GOG goal is to have all deliveries conducted in hospitals or clinics. The long-term plan is to upgrade the skills of all of the existing *Dai*s, but there should not be any further training of new *Dai*s or any attempt to create new *Dai*s. *Dai* training will eventually be discontinued, and *Dai*s will be phased out. However, some NGOs, including SEWA, perceive *Dai*s' role as central in the RCH-oriented health programmes. SEWA indicates that unless the primary health care infrastructure improves, *Dai*s will continue to provide various health services, including conducting deliveries. SEWA also considers the *Dai*s' work as a form of employment to provide women with some form of income, essential to meet their basic needs.

It seems that despite a span of 42 years (1957-1999), the initial objectives that led to the training of *Dai*s remain intact even today. This is because the rural health infrastructure is unable to meet the needs of the population, especially in delivery services. *Dai*s continue to conduct deliveries, advise women about prenatal care, and promote family planning. It appears that the shortfall is not confined to rural areas but is found in the urban areas. *Dai*s are present in the urban areas, mainly in the slums. They cater to the needs of the poor and those who are reluctant to go to the public hospitals. SEWA's (1997-1998) baseline health survey found that women members either go to private hospitals or clinics for health services/deliveries or procure the services of *Dai*s.

Women's health in Gujarat is affected by multiple factors. This being the case, factors such as the environment, women's educational level, income (although the NFHS did not discuss this, SEWA's health baseline survey showed that women's incomes do have an impact on their families' health), nutritional status, age of marriage and conception, availability of contraception, birth spacing, and the availability of health services all play a role in affecting the IMR and MMR. It is within this context that the *Dai*s' work intersects and is examined.

The *Dai*s work within an environment where the state of most women's health is precarious to begin with. As noted previously, women's marginalised status in a patriarchal society is one cause for their ill health. This is the starting point for much of women's physical, social, and mental ill health. Another cultural norm that affects women's health is that they are considered someone else's property.[45] Females in India are married off early,[46] and again the NFHS data supported this (22% of females were married between the ages of 15 and 19 years). Early marriage coupled with early and multiple conceptions and short birth spacing all have deleterious repercussions on women's health. Compounding these issues is the lack of accessible health care services because of either cost or distance. Although the infrastructure is set up to provide decentralised and affordable delivery care and other health services, in reality this does not happen.[47] The *Dai*s therefore are the most accessible 'delivery care providers.' They are also a link between the women and the other health care providers. One of the ways that *Dai*s have been made part of the health care system is through training. Training the *Dai*s, paying them a nominal fee, issuing them with an ID card, and providing them with a *Dai* Delivery Kit (DDK) all ensure that *Dai*s remain connected to the health care system. These measures also allow female health workers to monitor *Dai*s' work. This is done through stock-keeping of the number of DDKs issued to the *Dai* compared with the number of deliveries conducted by her. FHWs also question the woman and ask her about the circumstances of the delivery.

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[45] Property has many connotations. Society considers her an outsider in her parents' home because she is born in one household but will live the rest of her life after marriage in another. Her economic, reproductive, and emotional contributions will be to her in-laws, although she receives her training in her parents' home.

[46] There is an unspoken rule that at a certain age marriage should occur. If a woman marries late, there is a general perception that it was probably due to some undesirable trait in her.

[47] As noted in the discussion, one reason is that health care personnel are not available. The other reason is that these workers are overworked and they juggle multiple programmes and demands on their time. Many feel frustrated because they feel that they are unable to do a good job as they see that it should be performed. Most of these workers are dedicated to their work. This was one of the main concerns of the health care personnel both in the urban and the rural areas (Chapter 7: Data Findings).

It was thought that training of *Dai*s would decrease the maternal mortality rate. However, a reexamination of the MMR in the early eighties indicated that there were other causes. In his working paper titled *Review of the Safe Motherhood Programme in India in the Context of Reproductive Health: Achievements, Issues, and Challenges*, Mavalankar (1999) noted that one of the causes for maternal mortality and morbidity is anaemia. Despite the wide distribution of iron and folic acid, nutritional anaemia continues to be high because there is no monitoring system to track the adequacy of the dosage or whether or not there is compliance in taking the supplements (Mavalankar, 1999).

The findings listed in the working paper (Mavalankar, 1999) showed that maternal mortality would decrease if there were facilities that provided emergency obstetric care to women who develop complications during deliveries. It also noted that it is not possible to predict in advance who will develop complications during delivery and that maternal deaths usually occur a few days after the delivery, so that there is time to refer women to hospital (Mavalankar, 1999). Furthermore, once major obstetric complications set in, then even the trained *Dai*s or the nurse would not be able to do anything because at this juncture the woman requires either surgical intervention or medical support (Mavalankar, 1999). All of these observations have important implications for *Dai*s.

Because one of the causes of high MMR was attributed to *Dai*s' participation, these data and the roles of the sociocultural and economic factors point towards other issues that impact the work of the *Dai*s, indicating that the causes of high IMR and MMR are numerous and complex. Mavalankar's (1999) study highlighted the constraints under which *Dai*s work and disproved the common perceptions that high MMR occurs because they do not recognise the signs and symptoms of at-risk deliveries or they do not refer women to hospitals. It seems that even if *Dai*s were to recognise these signs and symptoms, death would occur if there were no appropriate health care facilities to handle the complications. The Gujarat government acknowledges *Dai*s' contributions because they are able to bridge the shortfall in health care delivery services. The health care system is unable to bridge this shortfall because it is stretched to the limits.

Conclusion

Dais' work is influenced from various levels and directions. Health policies formulated at governmental and international levels are operationalised on the ground. The WHO's (1978) Health for All (HFA) is one such framework that has influenced the health policies of India and Gujarat. It has provided them with a feasible and workable structure to address the health needs of citizens. Appropriate technology, affordability, availability, accessibility, and acceptability are hallmarks of HFA. *Dai*s meet all of these stipulations. They are accessible to women and children and deliver appropriate care. Although the implementation of the HFA has given *Dais* an entry point into the health care system and provided them with a formal link, the HFA is oriented towards meeting the needs of the system and not *Dais*; and, as a result, they are a target for various interventions. What has not been taken into account is that apart from being health practitioners, *Dai*s are women who are subject to the same socioeconomic and political rules that marginalise women in general. As a result, the HFA framework has not benefited *Dai*s because it has failed to consider and address these issues. The RCH framework, however, focusses on human resource development; in particular, women's role.

Participants at the RCH conference noted that women become empowered if there are opportunities to fulfil their potential.

> Key to this new approach is empowering women and providing them with more choices through expanded access to education and health services and promoting skill development and employment . . . and eliminating all practices that discriminate against women, including those in the workplace and those affecting access to credit, control over property and social security. (UNFPA, 1994, pp. 4-10)

The participants also noted that women are the poorest of the poor, and therefore they are the ones who suffer from the effects of structural barriers that impede their development. Their observations were supported by various discussions and research data (Hirway & Mahadevia, 1999; Jejeebhoy, 1995; Mahadevia, 1999; NFHS, 1993; SEWA, 1997-98). Women of Gujarat do encounter these barriers that affect their health. They are subject to stresses that adversely affect their physical and mental health at various points in their lives. The Gujarat government's goal to adopt the RCH framework is a move in the right direction. If implemented well, it has the potential to increase women's choices and address their health using a life-cycle approach.

For *Dais* to benefit from the RCH implementation in Gujarat, there has to be a change at two levels. The first is in the way that their work is valued within the health care system. As of now, *Dais* make their entry into the health care system as unequals. Their work is judged based on biomedical procedures, standards, and knowledge and not on its own merits. Therefore, the monetary value of their work is low. The second is a shift in the way that their contributions are linked to the needs of citizens and the health care system. Although meeting the needs of both is important, *Dais*' work should be an avenue to empower them and expand their access to opportunities, skill development, and employment and to "eliminat[e] all practices that discriminate against women, including those in the workplace" (UNFPA, 1994, p. 10). *Dais*' contribution is not merely health care work (as indicated in the HFA framework), but also part of a larger movement by SEWA and other local NGOs to end inequities against women in Gujarat and India.

CHAPTER 4

THE SELF-EMPLOYED WOMEN'S ASSOCIATION (SEWA)

Introduction

In this chapter I give a brief outline of SEWA's history, its organisational structure, and the establishment of SEWA Health Co-operative. It includes an account of SEWA's multiple initiatives to address the well-being of its members. The background information about SEWA provides greater insights into the work of the Health Co-operative, its various health programmes, and its work with *Dai*s. On the whole, the decentralisation of the Health Co-operative's (and SEWA's) programmes and its involvement with *Dai*s embody the principles of the *Health for All* (HFA) and *Reproductive and Child Health* (RCH) frameworks, respectively. This link is discussed at the end of this chapter. Although each of SEWA's initiatives has a particular social and economic focus, together they form a coherent whole that impacts health either directly or indirectly. This is because SEWA women know that their health is inextricably linked to their ability to earn steady income. At the same time, they continue to work towards changing social structures that impede their progress and curtail their choices.

One initiative on which SEWA has placed a great emphasis is documentation and information dissemination. In 1990 SEWA set up its own academy where documentation work such as video, art, and plays are used to tell the stories of these women. The academy has also, in the past, conducted basic literacy classes to teach women to read and write. In addition, the SEWA Academy publishes a bi-weekly newsletter *Ansooya* (without malice or rancour) for its members and *Akash Ganga* (Milky Way) for young daughters of SEWA members.

Access to information is key to women's economic and social empowerment and education. SEWA also tries to educate the public about the issues that self-employed women face. However, SEWA leaders know that documentation and data dissemination are meaningful when women members are involved in the process. At the same time, SEWA encourages outsiders (researchers, writers, media personnel, members of other NGOs) and its own leaders to articulate these issues. In this way, SEWA's work is known nationally and internationally.

Rose (1992) presented a good, comprehensive account about SEWA and its initiatives. Her book chronicles SEWA's beginnings as a struggling organisation to its present state and its success. Other authors who have written about SEWA include Banerjee and Mitter, (1998); Bhatt (1987); Carr, Chen, and Jhabvala (1996); Jhabvala (1994); Martens and Mitter (1994); Mitter (1994). SEWA leaders and researchers who have written about SEWA's initiatives include Bhatt (1995, 1996); Chatterjee (1995, 1996, 1997a, 1997b, 1999, 2000); Chatterjee and Vyas (1996); Chatterjee, Waliya, and Kohli (1998); Jhabvala (1999); Jhabvala, Chatterjee, and Parikh (1996); Nanavaty (1997); and Pandya (1999). Shramshakti's (SEWA, 1989) landmark study provided excellent background data about informal workers in India. Other SEWA sources include Gujarat Mahila Housing SEWA Trust (1998); SEWA Academy (1997); SEWA Annual Reports (1988-1998); SEWA (1997-1998) Baseline Health Survey; SEWA (1993b, n.d.); and Video SEWA (1996). Foreign and local researchers (Schuler, Hashemi, & Pandit, 1995) and international agencies (Hauck, 1999) have provided good data about SEWA's initiatives and their impact on women.

SEWA's beginning in 1972 is rooted in union work. The goal of the organisation is to address self-employed women's economic concerns, because they are vulnerable to exploitation in the hands of merchants and contractors. As SEWA expanded, its work became more inclusive to meet other needs of its membership. In addition to promoting economic self-reliance through co-operatives, SEWA's endeavours include social security (childcare, health, housing and insurance), and capacity building (empowerment).[48] The organisation focusses on both financial and social services, which together affect women's health.

Women's needs should be the starting point for all activities, whether to build their capacities or to mainstream (formalise) their work (SEWA Annual Reports, 1988-1998). Chatterjee (1996) noted that "rather than equipping ourselves with a ready blueprint, our approach has been to start with our members' needs, demands, and priorities. The[y] have overwhelmingly pointed us to the following goals: full employment and self-reliance" (p. 8).

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[48] One good example is the SEWA Academy's class on leadership training. On the first day women are taught how to introduce themselves. This may appear to be a simple exercise, but in the context of South Asian culture, learning this has multiple ramifications for women's lives. A Gujarati woman, like many South Asian women, tends to introduce herself using teknonyms such as "wife of," "mother of," or "daughter of" and does not use her name. SEWA teaches women that although these identifiers are important, identifying themselves with their names is very important, because it is the first step towards valuing themselves as individuals in their own right. This is the beginning towards empowerment or capacity-building work.

SEWA therefore intersects at various points in women's lives through organising them into a collective, lobbying at the state level, and upgrading skills. All these strategies build women's confidence and promote their well-being. This philosophy guides SEWA's approach to *Dais*' work. The organisation regards *Dais* as integral members of the health care system who have important roles to play. *Dais* provide accessible and affordable care to women, and at the same time their work provides them with a form of employment in situations in which they may not have any other options for income generation.

Because the goal of my research is to explore the linkages between the work and the health of the *Dais* in Gujarat, and, in particular, the various perceptions of *Dais*' work and how these perceptions affect their health, SEWA provided the ideal research environment because it focusses on both economic and social issues. The organisation tries to enhance the image of self-employed women's work in the informal sector through education, political and social activism, and economic co-operatives.

SEWA: The Early Beginnings

SEWA began under the auspices of the Textile Labour Association (TLA), founded by Mahatma Gandhi and Ansooya Sarabhai in 1917. The TLA led a successful textile workers' strike based on Gandhi's approach of nonviolence and passive resistance. These founders envisioned the labour movement and unionisation as a social responsibility "to develop the whole human and not just the worker" (Bhatt; as cited in Rose, 1992, p. 40). Working on this premise, the TLA became involved in social work and economic development in the community in addition to its labour relations work. Some of the community development work that the TLA either promoted or participated in included medical aid, library services, housing, the provision of co-operative credit services, and time and financial management.

In 1954 the Women's Wing was created within the TLA to assist the wives and families of the mill workers, and by 1968 it was offering a myriad of classes that focussed on vocational training. Ela Bhatt, the founder of SEWA, was working at the TLA, where she was involved in representing the Association in Labour Court. All this changed, however, in 1971, when she met with a group of migrant women workers. These women were headloaders[49] and cartpullers who, together with their families, lived on the footpath. They approached the TLA for assistance for their housing needs. While TLA listened to their needs for adequate shelter, other issues began to emerge that told a story of exploitation by the cloth traders 'for whom they worked.' The women who worked as headloaders reported that these traders would underpay them for the work they did because the merchants did not maintain accurate records of either the amount of cloth (load) they transported or the distance the women travelled. Despite their long working hours (up to 16 hours a day), many of them earned less than Rs. 3 per day (US 30¢ at the time) which did not provide the minimum sustenance for their families. Following the meeting, Ela Bhatt wrote an article outlining the plight of the cartpullers and the headloaders. The cloth merchants countered these charges with their own evidence of fair play, and the Women's Wing reprinted the merchants' claims on cards and distributed them amongst the headloaders and the cartpullers for leverage. This action attracted the attention of other self-employed women who were also struggling with various degrees of social and economic exploitation.

This first successful action led to other self-employed women approaching the TLA to address their grievances.[50] A public meeting was organised, and women from other trades recounted over and over again physical abuses at the hands of police and municipal authorities in Ahmedabad and their struggles to make ends meet. It was during this meeting that the group decided to form an association of their own that understood self-employed workers' economic and social realities. Thus in December 1971 the Self-Employed Women's Association (SEWA) came into being. It took another four months for SEWA to become formally registered as a trade union because, under Indian labour laws at the time, unions were recognised within the context of a well-defined employee-employer relationship. But SEWA's broad interpretation of unionisation maintained that unions could exist *for* the workers and not only *against* the employer (Rose, 1992, p. 45). In 1981 SEWA separated from the TLA for ideological and political reasons. Ela

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[49] Women who usually carry loads such as cloth on their heads to take the supplies from one merchant to another within the city.

[50] One such group was used-garment traders. These women carry kitchen utensils in large baskets on their heads, walk in various middle-income resident enclaves, and trade them for used garments. These garments are repaired, washed, ironed, and then sold in the markets. Most of the used garment traders are *Vaghris*, one of the many tribes that have been designated as Backward Castes by India's Constitution.

Bhatt described this separation as allowing for an "incredible sense of freedom. It felt like a daughter's righteous struggle. We had left the nest" (p. 80).

SEWA's original guiding philosophy is based on the Gandhian principles of *satya* (truth), *ahimsa* (non-violence), *sarvadharma* (integrating all faiths, all people), and *Khadi* (propagation of local employment and self-reliance). This philosophy is reaffirmed daily and at the beginning of all SEWA initiatives, when everyone sings both the secular and religious songs. In addition, SEWA members perceive their organisation as comprising three movements: labour, co-operative, and women. Through its labour movement SEWA continues to promote the idea that self-employed workers, like salaried employees, should have fair wages, work in a safe environment, and have equal protection under the labour laws. The co-operative movement, first and foremost, provides the workers with an alternative economic system in which they are both the producers and the owners of their products and the labour, and therefore a lever for change. SEWA works to change the traditional framework of social structures to promote the women's movement. It believes that women need economic and social security in order to find avenues to initiate social changes and create new opportunities for themselves and for others. Thus SEWA's approach has been to begin with the women themselves and to strategise their plans for action based on their skills and needs. SEWA's successful organising has been due to the efforts of poor women in leadership roles, because they decide the issues that need to be addressed. It is SEWA's contention that

> poor women's growth, development and employment occurs when they have work and income security and food security. It also occurs when they are healthy, able to have child care and have a roof over their heads, . . . to empower themselves [women] and increase their bargaining power, the only viable strategy. (SEWA Annual Report, 1997, pp. 12-13)

According to SEWA's Annual Report (1998), self-employed workers constitute 93% of India's labour force, of which 94% are female. Furthermore, the self-employed contribute 64% to India's GDP annually. The report stated that, despite these staggering statistics, self-employed workers—in particular, women—remain uncounted, undercounted, or invisible.

Over the years SEWA has transformed itself into a movement in addition to being a union organisation (Figure 5). SEWA's philosophy that marginalised women can be the innovators and the directors of change has taken root in other parts of the world and in India

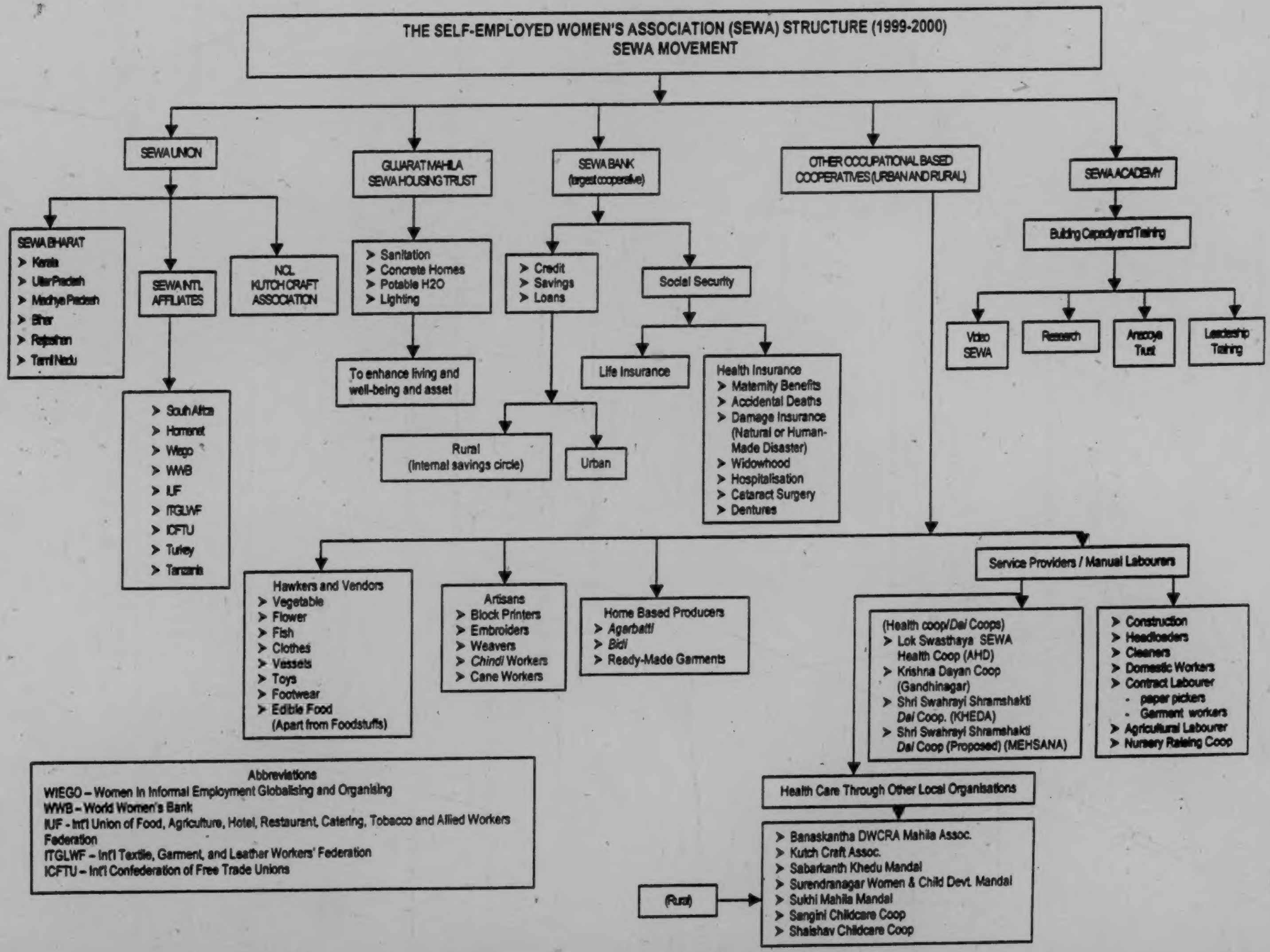

THE SELF-EMPLOYED WOMEN'S ASSOCIATION (SEWA) STRUCTURE (1999-2000)
SEWA MOVEMENT
SEWA UNION
SEWA BHARAT
➤ Kerala
➤ Uttar Pradesh
➤ Madhya Pradesh
➤ Bihar
➤ Rajasthan
➤ Tamil Nadu
SEWA INTL AFFLIATES
➤ South Africa
➤ Homenet
➤ Wiego
➤ WWB
➤ IUF
➤ ITGLWF
➤ ICFTU
➤ Turkey
➤ Tanzania
NCL KUTCH CRAFT ASSOCIATION
GUJARAT MAHILA SEWA HOUSING TRUST
➤ Sanitation
➤ Concrete Homes
➤ Potable H2O
➤ Lighting
To enhance living and well-being and asset
SEWA BANK (largest cooperative)
➤ Credit
➤ Savings
➤ Loans
Rural (Internal savings circle)
Urban
Social Security
Life Insurance
Health Insurance
➤ Maternity Benefits
➤ Accidental Deaths
➤ Damage Insurance (Natural or Human-Made Disaster)
➤ Widowhood
➤ Hospitalisation
➤ Cataract Surgery
➤ Dentures
OTHER OCCUPATIONAL BASED COOPERATIVES (URBAN AND RURAL)
SEWA ACADEMY
Building Capacity and Training
Video SEWA
Research
Aroogya Trust
Leadership Training
Hawkers and Vendors
➤ Vegetable
➤ Flower
➤ Fish
➤ Clothes
➤ Vessels
➤ Toys
➤ Footwear
➤ Edible Food (Apart from Foodstuffs)
Artisans
➤ Block Printers
➤ Embroiders
➤ Weavers
➤ Chindi Workers
➤ Cane Workers
Home Based Producers
➤ Agarbatti
➤ Bidi
➤ Ready-Made Garments
Service Providers / Manual Labourers
(Health coop/Dai Coops)
➤ Lok Swasthaya SEWA Health Coop (AHD)
➤ Krishna Dayan Coop (Gandhinagar)
➤ Shri Swahrayi Shramshakti Dai Coop. (KHEDA)
➤ Shri Swahrayi Shramshakti Dai Coop (Proposed) (MEHSANA)
➤ Construction
➤ Headloaders
➤ Cleaners
➤ Domestic Workers
➤ Contract Labourer
- paper pickers
- Garment workers
➤ Agricultural Labourer
➤ Nursery Raising Coop
Health Care Through Other Local Organisations
➤ Banaskantha DWCRA Mahila Assoc.
➤ Kutch Craft Assoc.
➤ Sabarkanth Khedu Mandal
➤ Surendranagar Women & Child Devt. Mandal
➤ Sukhi Mahila Mandal
➤ Sangini Childcare Coop
➤ Shaishav Childcare Coop
(Rural)
Abbreviations
WIEGO – Women in Informal Employment Globalising and Organising
WWB – World Women's Bank
IUF - Int'l Union of Food, Agriculture, Hotel, Restaurant, Catering, Tobacco and Allied Workers Federation
ITGLWF – Int'l Textile, Garment, and Leather Workers' Federation
ICFTU – Int'l Confederation of Free Trade Unions

Figure 5. SEWA structure. (SEWA Annual Report, 1997 and fieldwork data, 1999-2000).

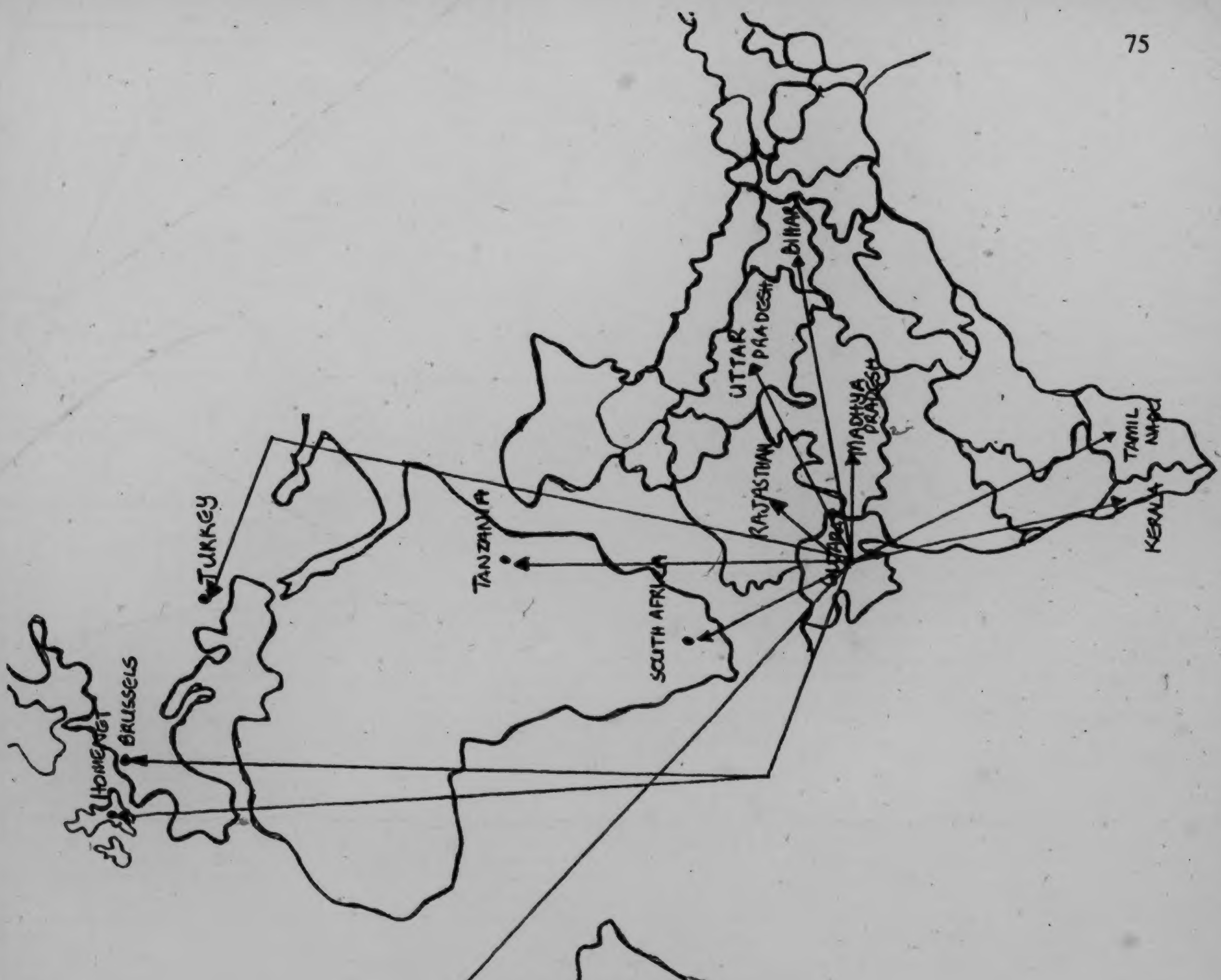
(Map 3). Although SEWA remains the largest union in Gujarat, its movement has taken root in Kerala, Madhya Pradesh, Bihar, Rajasthan, and Uttar Pradesh. Its worldwide affiliations include either working in partnerships with other organisations that address the issues of self-employed workers or founding organisations such as the Women's World Banking and HomeNet, which work with home-based workers worldwide (Map 3).

SEWA's Organisational Structure

Since its inception as a union in 1972, SEWA's membership has grown each year as more women come to learn about its work and the advantages of being unionised. In 1973 SEWA's membership was 320; in 1998 its membership in Gujarat increased to 142,810 (rural membership 43,617 and urban 99,193), and its all-India membership was 209,250 (SEWA Annual Report, 1998). SEWA union membership is open to all self-employed women aged 15 and older, and the membership fee is Rs. 5 per year. Every three years SEWA women elect their representatives to the trade council, and members of this council then elect the executive committee of SEWA.

SEWA focusses on improving women's economic conditions and has found that economic improvements lead to the awareness of issues in other aspects of women's lives that have direct impact on their families and on them. It has been observed that economic empowerment of women has enabled them to deal with health issues, social security, education, housing, and long-term security, which had seemed 'marginal' compared to seeking ways for daily survival.

SEWA's union work has become a model for women to follow in order to empower themselves and address structural inequities that impede their development. SEWA has expanded and continues to expand and adapt to meet members' needs. It is a union that manages and provides guidance to various co-operatives of various trades and services in both rural and urban areas, such as SEWA Bank, SEWA Housing Trust, SEWA Academy, and supportive services. Women members are the focus for all the development work. Each service aims to strengthen women's capabilities, to instil a sense of self-worth, and to increase their visibility.


UTTAR PRADESH
BIHAR
MADHYA PRADESH
RAJASTHAN
GUJARAT
TAMIL NADU
KERALA
TANZANIA
SOUTH AFRICA
TURKEY
HOMENET
BRUSSELS
NEW YORK

Map 3. Work of SEWA in India and other parts of the world (fieldwork data [SEWA], 1999).

Physical Structure of SEWA

When I arrived in Ahmedabad in 1999, the physical layout of SEWA had changed from that described by Rose (1992). This change parallels SEWA's expansion of services and membership and reflects its flexibility to adapt and meet the changing needs of its members. A key feature is decentralisation of services and offices to ensure accessibility.

Once one crosses the Ellis Bridge and reaches the main road, the first sign of SEWA is the façade of a brick building. This is the main building, known as the SEWA Reception Centre. The brick façade hides the maze found at the back, where SEWA's diverse work is carried out. In many ways the labyrinth reflects SEWA's diversity and its ability to find multiple niches to establish itself. Apart from the SEWA Reception Centre, there are three other buildings of various sizes nearby that house SEWA administrative and union offices, various co-operatives offices, meeting rooms, and a medicine shop.

The SEWA Reception Centre has four levels and is the hub of all SEWA activities. Each level consists of a large open space with one or two rooms at the side. Although work at SEWA officially begins at 11:00 a.m., those who have to go into the field are usually at the SEWA office earlier to take one of the jeeps or the local buses to their destinations. Every morning, before the day's work is commenced, the foyer of the Reception Centre is transformed into a prayer space. SEWA women of all religions, castes, socioeconomic backgrounds, and age gather to sing secular and religious songs, affirm Gandhi's five pillars (see above), and do stretching exercises. The foyer then becomes the meeting place for women who come from outlying rural areas or districts, or other parts of the city. This is where SEWA members come to meet with other women, to consult with SEWA workers or coordinators on various matters, and to attend formal meetings of their co-operatives/unions. At one corner is a small cubicle where a SEWA Bank worker collects money for deposits from women. At the other side of the foyer is a long table where SEWA handicrafts are sold. Outside the Reception Centre two brothers operate a tea stall that sells spicy *chai* and coffee to SEWA visitors and women. At the back of the Reception Centre, there is a courtyard that opens into an alley to other buildings where one of the Health Co-operative's main medical shops, meeting rooms, union offices, and telephone and fax services are located.

Across the Ellis Bridge, on the other side of the Sabarmati River, is where the main branch of SEWA Bank and SEWA Academy are located. They are opposite one another. The office of SEWA Housing Trust is found in another commercial building, but within walking distance to other SEWA offices. SEWA Housing Trust is involved in slum-improvement projects. It works with the municipality to bring basic services such as potable water, electricity, and proper sewage and garbage disposal to slum dwellers. At the same time it works with SEWA Health Co-operative to teach members about the causes of food and water-borne diseases and their prevention. Proper housing is also critical for another reason. For many women their homes are their only asset, in which they produce goods and provide services. If they lose their homes because of flood or communal violence, they lose their source of income. That is why SEWA Bank offers insurance to protect women's assets.

SEWA's work is not confined to only these few buildings or locations. For example, embroidery, patchwork, card-and-folder making, and dyeing and tie-dyeing are carried out in a building found in another part of the city. Every morning bank workers go to outlying rural and urban areas to collect deposits from women who are unable to come to the SEWA Bank. The Video SEWA team films women at work at different locations, but edits the film at the Academy. Likewise, health care workers organise mobile clinics to bring health care to the doorstep of the communities, operate small health care centres in urban and rural Gujarat, manage various medical shops that sell Locost (generic and manufactured locally) medicines, provide information to members about SEWA's work and health insurance schemes, and conduct research. SEWA also provides supportive services such as offering crèches to children of women workers under the ICDS programme. SEWA *Gram Vikas* (Village Development) is active in teaching communities and women about water conservation, the prevention of environmental degradation through tree planting, and income-generation schemes such as crafts and other indigenous work. SEWA Craft promotes and sells the various handcrafts that SEWA women make to local and overseas markets.

Profile of SEWA Members

There are three types of self-employed workers who constitute SEWA's membership. They are:

1. Hawkers and vendors who either hawk their wares such as household goods and clothes or sell edible items such as vegetables, fruits, fish and eggs. Their membership in 1998 was 10,642 and in 2002 it was 39 456;
2. Home-based workers such as weavers, potters, *bidi* and *agarbatti* makers, *papad* rollers, ready-made garment seamstresses, processors of agricultural products and artisans. Their membership in 1998 was 47,938 while in 2002 it was 141 458; and
3. Manual labourers and service providers such as agricultural labourers, construction workers, contract workers and launderers, and health workers such as *Dai*s, health trainers, and pharmacy assistants. Their membership in 1998 totalled 84,230 and in 2002 it increased to 354 760.

Although women from the above categories constitute SEWA's main membership, there is a fourth group of women who are making an entry into SEWA. These are SEWA's second-generation members, whose introduction into the organisation has been either through their female relatives who are current SEWA members or through other women. Their ages range from 18 to 30 years, and education from Grade 9 to university levels. In the health co-operative these members include SEWA's grassroots researchers and administrators who one day will become SEWA's leaders. The entry of these women aligns closely with SEWA's philosophy of grooming leaders of tomorrow from its membership. The goal is to have leaders who understand the desires of membership, articulate them in an effective manner, and provide avenues for SEWA women to voice them. Being able to put their own identified needs in their own words is an empowering experience for illiterate women.

SEWA's 10 points, developed by its members, are the guiding principles for any initiatives on which it embarks and also serve as an evaluative tool for all its work. These 10 points are:

1. Have the members obtained more **employment**?
2. Has their **income** increased?

3. Have they obtained **food and nutrition**?
4. Has their **health** been safeguarded?
5. Have they obtained **childcare**?
6. Have they obtained or improved their **housing**?
7. Have their **assets** increased (such as their own savings, land, house, workspace, tools, share in co-operatives)?
8. Has the workers' **organisational** strength increased?
9. Has their **leadership** capacity been enhanced?
10. Have they become **self-reliant** both collectively and individually?

Each of these 10 points has ramifications for women and their families. The absence of any one of the components has a direct impact on their lives. For example, if a woman does not have steady employment and income, it affects her nutritional intake, leading to ill health, inability to work, loss of income, debt, and inability to care for her family, a vicious cycle that continues until it is disrupted. Inability to care for her family leads to feelings of low self-worth, isolation, and abuse. Being aware of these linkages has led SEWA to develop a health approach that is sensitive to its members' needs.

SEWA's Health Approach

> As long as my arms and legs move and my eyes can see
> I can work and earn. After that who knows? For us poor women, sister,
> our bodies and health are our only wealth. (SEWA Annual Report, 1988, p. 79)

SEWA has attempted to address the health needs of its members using an integrated approach. This means approaching health not only from the curative perspective, but also through health education and health promotion. SEWA believes that physical and mental health are linked to the social and economic needs of the women. These include housing, childcare, clean drinking water, clean environment, basic education, accessible maternal and childcare, insurance, and credit and assets. In addition to these, SEWA recognises that the political empowerment of women would provide them with the opportunities to become part of the larger decision-making mechanism of society at the national and international levels.

SEWA's integrated health approach is thus holistic in nature, and once a need is identified, it is the SEWA women at the grassroots level who implement the health programmes and disseminate information to members. This approach is rooted in SEWA's goal to become a 'people's movement.' Based on this goal, the Health Co-operative of SEWA conducted a baseline survey in 1997. The objectives were

- to understand members' existing health needs
- to determine whether SEWA's health services were accessible to women
- to ascertain whether the health services met women's needs
- to identify new health issues.

SEWA women themselves have noted that their health is their only wealth.

Historical Beginnings of the Health Co-operative

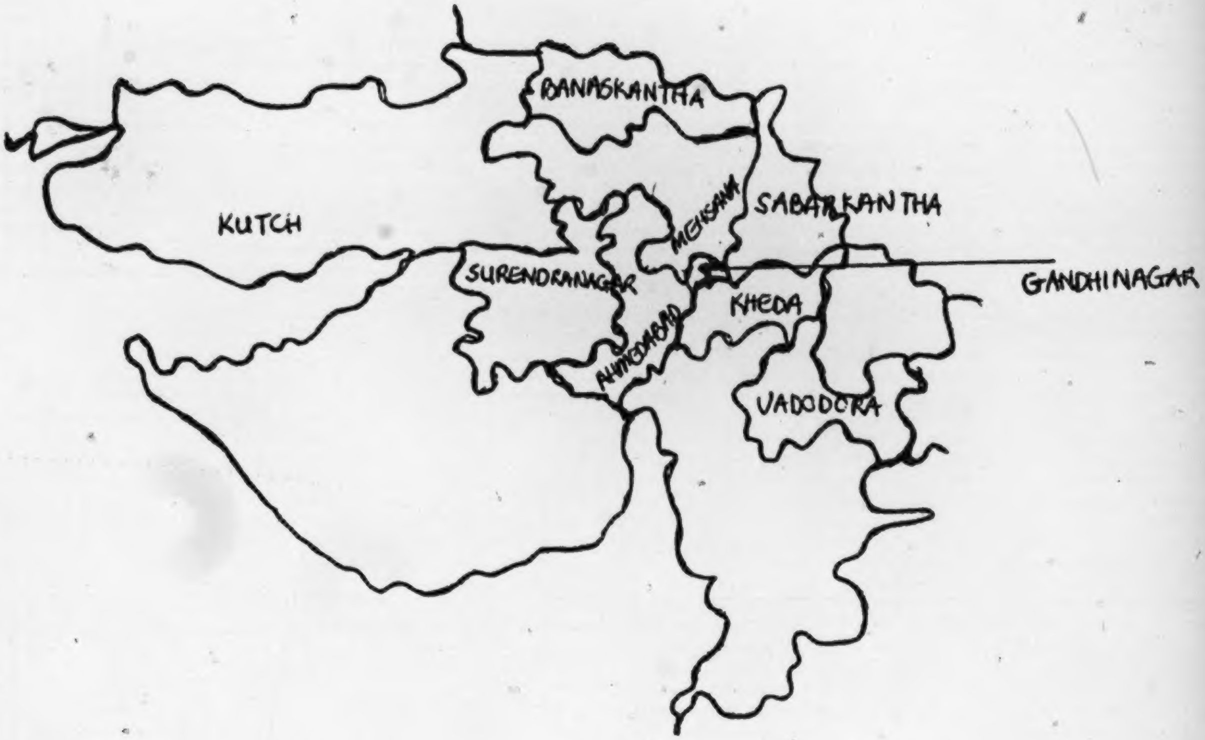
SEWA's health care provisions come under the auspices of supportive services together with childcare, housing, insurance, training, research, savings, and credit (Figure 5). In 1990 health care service provision became a co-operative known as the *Shri Swashrayi Mahila Lok Swasthya SEWA Sahakari Mandli* Ltd. (henceforth the Health Co-operative).

Over the years SEWA had experimented with various health initiatives for its members, and in 1975 it organised medical check-ups for 350 of its members to identify their specific health needs and concerns. For this event 40 doctors donated their time, and the SEWA Trust assumed the remaining costs. In addition, this event enabled the SEWA organisers to assist women in linking with other existing health structures and services. The follow-up from this sponsored health event was limited, however. At the same time members continued to articulate their health needs, and in 1985 a Community Health Programme (CHP) came into being. The CHP, which came to be known as *Jagruti,* meaning awareness, began as a support service for SEWA women.

Jagruti's initial work began in the slums of Ahmedabad City and in the rural areas of Kheda and Ahmedabad districts, focussing on curative and preventive health issues. The aim was to mobilise women around health and to teach them about their bodies and the linkages between ill health and economic loss. One such health initiative was related to pregnancy. SEWA found that most of its women members were malnourished, and pregnancy further affected their health. Poverty, lack of income and work security, and absence of any social and welfare benefits forced them to work right up to when the labour pains began. Based on this observation, *Jagruti* initiated its own maternity benefits by providing pregnant women with a kilo of *ghee* (clarified butter) and a stipend of Rs. 100 *before* the birth and linking them to prenatal services in their area. The stipend of Rs. 100 was given to a woman so that she would have the income security that would allow her to rest and eat nutritional food. The *ghee* was given in the belief that it would provide the woman with the high calories and nutrition that are essential for her and her unborn child (whether this actually occurred is debatable because a woman in Indian society usually eats last). SEWA utilised the cultural connotations of pregnancy (untouchability and pollution) to ensure that women consumed the *ghee*. That is why it was given before the delivery and to the woman.

In addition, members of *Jagruti* began to explore the idea of dispensing low-cost, generic drugs to its members and disseminating health information to communities. It was felt that the best way to achieve this would be to train women from the communities who lived among SEWA members and their families. These women would be known as community health workers (CHWs), who would provide accessible and affordable health care and leadership to other women. As SEWA's membership expanded, the demand for more comprehensive health services increased. Thus in 1990 SEWA decided to register the fledgling Community Health Programme as a co-operative, *Shri Swashrayi Mahila Lok Swasthya SEWA Sahakari Mandli* Ltd., in Ahmedabad. The co-operative would then fulfil SEWA's two objectives: First, members would have access to affordable health services; and second, the co-operative would provide employment to the women. The long-term goal of the co-operative at the time was (and continues to be) to become economically self-reliant through various income generation schemes while continuing to provide accessible and affordable health care to members.

At the present time the health co-operative's work can be found in nine districts of Gujarat (Map 4). To avoid duplication of organisational structure at the district level, the health team has established linkages with existing SEWA initiatives in five districts, and in the other districts, autonomous health co-operatives have been established that are managed by the shareholders, who are also its health care providers. As of 1999 there were approximately 58 CHWs distributed throughout the nine districts and the city. SEWA considers carefully when choosing a CHW: She must be someone who commands the respect of her community, possesses leadership qualities, has flexible time schedules, and is dedicated and willing to learn. Although


BANASKANTHA
KUTCH
MEHSANA
SABARKANTHA
SURENDRANAGAR
GANDHINAGAR
KHEDA
AHMEDABAD
VADODORA

Map 4 .SEWA's Health Co-operative's work in the nine districts (fieldwork data [SEWA], 1999) knowing how to read and write is an asset, SEWA's experiences show that illiteracy is not a barrier to effective health care provision. In fact, these women have developed unique ways of identifying various diseases and dispensing the appropriate medications. Thus by focussing on health, SEWA organisers have been able to reach out to women and make an entry into a community, which otherwise would be impossible.

SEWA Health Co-operative

Membership and Organisational Structure

A woman gains membership into a Health Co-operative by purchasing one share at Rs. 100[51] and paying a membership fee of Rs. 1. As a shareholder, her rights and duties are governed by the co-operative's by-laws, which include the right to vote every three years to elect the Executive Committee. Being a member of the Health Co-operative allows her and others to determine the cost of her labour and initiate changes as a collective (see Figure 6).

The health supervisors provide an important link between the CHWs and the health administrators (health coordinator and the chair of the Co-operative). As of 1999 nine health supervisors have overseen the Health Co-operatives' work in nine districts (Figure 6). Their education range from a baccalaureate in sociology to Grade 3. None of them had prior health training or background; their health knowledge was based on their life experiences and observations around them. These health supervisors were the initial CHWs of SEWA's Community Health Programme, which began in the slums of Ahmedabad City and rural Ahmedabad District. In addition to their on-the-job "training," these women received further training from local doctors and an Ahmedabad based nongovernmental organisation (NGO) called CHETNA. The CHETNA training took about two years and included topics such as first aid, nutrition, women and children's health, immunisations, and primary health care.

With increasing membership spread over a wide geographical region, the challenge for the Health Co-operative was to ensure that health care continued to be accessible to members. The Health Co-operative attempted to address this by decentralising its health work at the district level. In addition to decentralisation, it has created a spearhead team. The spearhead team is

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[51] During my fieldwork between 1999 and 2000, the exchange rate was approximately C $1 = Rs. 38.

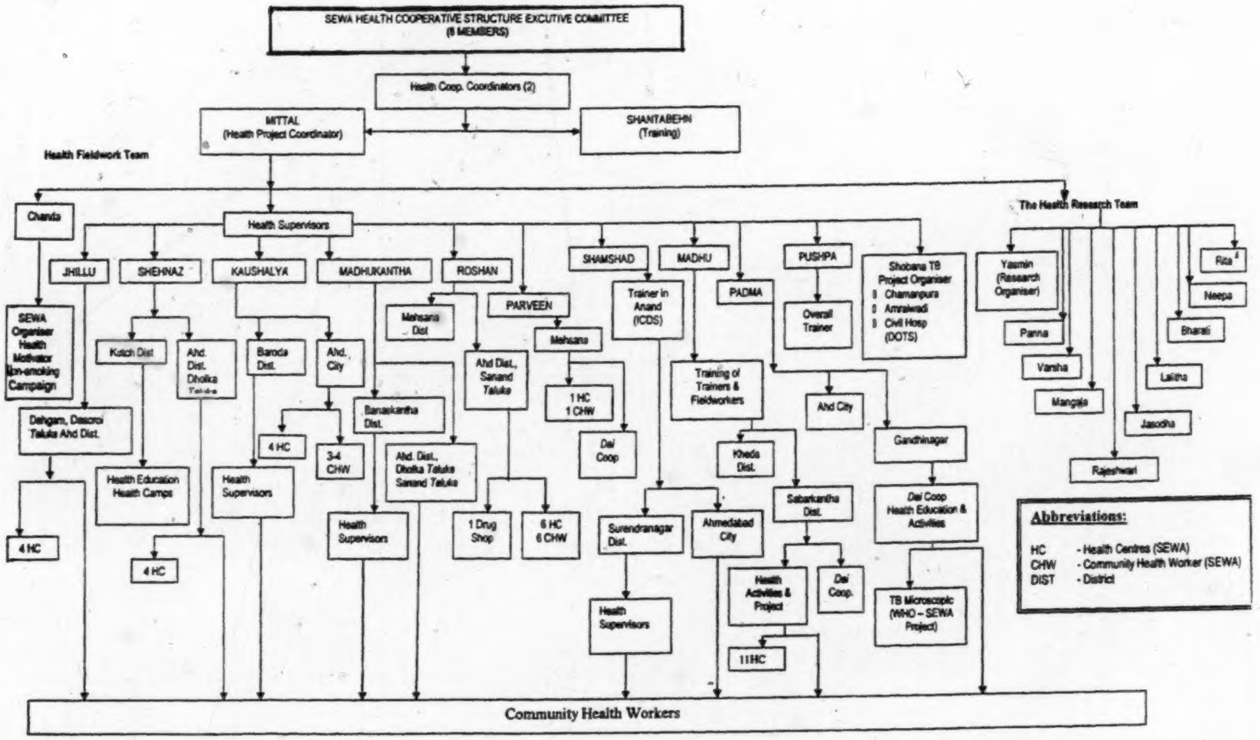
SEWA HEALTH COOPERATIVE STRUCTURE EXCUTIVE COMMITTEE (8 MEMBERS)
Health Coop. Coordinators (2)
MITTAL (Health Project Coordinator)
SHANTABEHN (Training)
Health Fieldwork Team
The Health Research Team
Chanda
Health Supervisors
JHILLU
SHEHNAZ
KAUSHALYA
MADHUKANTHA
ROSHAN
PARVEEN
SHAMSHAD
MADHU
PADMA
PUSHPA
Shobana TB Project Organiser
Chamanpura
Amraiwadi
Civil Hosp (DOTS)
SEWA Organiser Health Motivator Non-smoking Campaign
Dehgam, Dascroi Taluka Ahd Dist.
4 HC
Kutch Dist
Ahd. Dist. Dholka Taluka
Health Education Health Camps
4 HC
Baroda Dist.
Ahd. City
4 HC
3-4 CHW
Health Supervisors
Banaskantha Dist.
Health Supervisors
Mehsana Dist
Ahd Dist., Sanand Taluka
Ahd. Dist., Dholka Taluka Sanand Taluka
1 Drug Shop
6 HC 6 CHW
Mehsana
1 HC 1 CHW
Dai Coop
Trainer in Anand (ICDS)
Surendranagar Dist.
Health Supervisors
Ahmedabad City
Training of Trainers & Fieldworkers
Kheda Dist.
Sabarkantha Dist.
Health Activities & Project
Dai Coop.
11HC
Overall Trainer
Ahd City
Gandhinagar
Dai Coop Health Education & Activities
TB Microscopic (WHO – SEWA Project)
Yasmin (Research Organiser)
Panna
Varsha
Mangala
Rajeshwari
Jasodha
Lalitha
Bharati
Neepa
Rita
Community Health Workers
Abbreviations:
HC - Health Centres (SEWA)
CHW - Community Health Worker (SEWA)
DIST - District

Figure 6. SEWA Health Co-operative structure (fieldwork data, 1999-2000).

comprised of a core group of women who represent each district. The team meets once a month to discuss the various health, economic, and social issues of each district, and these are brought forward and discussed at the main SEWA level. This process promotes accountability to members and ensures that their health needs and concerns are addressed. Membership in the spearhead team provides women with the opportunity to learn from one another, understand multiple health issues, and support one another in their work.

Initiatives of the Health Co-operative

Health training and refreshers. In addition to the formal teaching and learning, CHWs informally teach families during their rounds in their assigned areas. CHWs provide information for preparing and storing clean water, sanitation, family planning, nutrition, primary health care, and adolescent health to young girls. Periodical refreshers are given to CHWs to ensure that their knowledge remains current. Refreshers also provide opportunities for these women to share their experiences with one another. The Health Co-operative has worked in partnerships with other SEWA services to construct smokeless *chulhas* (stoves) and toilets. One of SEWA's pioneer founders and a member of the Health Co-operative, Chandabehn has been campaigning vigorously to increase awareness about the adverse impact of *gutkha* (a tobacco product) and the consumption of illicit alcohol. The co-operative has begun to spread information about AIDS through videos, banners, and pamphlets.

Health research. In 1996 SEWA hired 10 women to work as health researchers. They received some training from the SEWA Academy researchers. Between 1997 and 1998 the health researchers conducted baseline surveys in nine districts where the co-operative's work was carried out. These researchers were given opportunities to present their results to the SEWA health members and team at the Reception Centre in October 1999. The baseline surveys provided data for the Health Co-operative to evaluate its current health work and plan future services. In addition, the research provided many of these young women with opportunities to develop their leadership skills. Currently, some of the health researchers are involved in occupational and nutritional researches, and others assist in organising the mobile health clinics with SEWA supervisors and CHWs.

Occupational health. The Health Co-operative had liaised with the National Institute of Occupational Health (NIOH) to educate SEWA tobacco workers and owners about the harmful effects of nicotine. The tobacco workers pick the leaves with their bare hands and inhale the nicotine during harvesting. The NIOH, SEWA health workers and tobacco organisers encourage women to use protective equipment such as gloves and facemasks, but convincing these women is an uphill task. They understand the benefits of protective equipment, but their reluctance stems from their fear of its impeding their productivity and affecting their income. Apart from tobacco workers, the SEWA health team and the SEWA *Gram Vikas* encourage women who are embroiderers to go for regular eye check-ups. These women do their fine needlework in poor light that causes strain to their eyes. The end result is that many of them are unable to do embroidery work by their early 40s.

The Health Co-operative worked with the National Institute of Design (NID) to create ergonomically designed equipment for *agarbatti* (incense) rollers to reduce body strain and sickles to prevent agricultural workers from accidentally cutting themselves while harvesting.

Insurance. In 1992 SEWA Bank, in consultation with SEWA leaders, embarked on an innovative insurance programme geared to the needs of self-employed women. SEWA was aware that when a woman falls ill and is unable to work, the financial impact on her family is disastrous. Many do not have any financial recourse to fall back on during this period. In addition to illness, loss of income occurs when women lose their personal assets (house, machines, and tools) from flood or communal riots. SEWA Bank tailored its insurance schemes to assist women when they are financially most vulnerable. At the present time SEWA's insurance coverage includes maternity, assets, accidental deaths, and hospitalisation. It also offers life insurance to women and their husbands.

The maternity benefit is linked to the Health Co-operative's programme of ensuring that women get adequate rest and nutrition when they are pregnant. A pregnant woman fills out a form at the medical shop at SEWA. She then receives Rs. 300 before her delivery. In addition to receiving the monetary benefits, she receives information regarding antenatal and postnatal care in her area and tablets for iron, folic acid, and calcium, and her weight is taken. There is no limit on the number of deliveries; however, if she is a multipara (already has two or three children) then she receives information on various family-planning methods.

Future plans include coverage for dentures, spectacles, hearing aids and cataracts to meet the needs of its aging members. In addition, it is planning to create an old age pension plan for income security for aging members unable to work.

Income-generation schemes. The Health Co-operative manages three medical shops: one in Ahmedabad District and two in Ahmedabad City. SEWA sells generic drugs at low cost to its members and to the public. It purchases these medications in bulk and is able to pass down the savings to its customers. Initially, there were some scepticism regarding the effectiveness of these low-cost medications amongst members and the public; however, with education and instructions, these sceptical clients were convinced of the drugs' effectiveness. In 1999 the revenue generated from the sale of the generic drugs was Rs. 5.8 million (M. Chatterjee, personal communication, November 30, 1999).

Another way that the Health Co-operative generates revenue is through health training conducted by its members. When a CHW or a supervisor provides health training to other co-operative members, a fee is charged for the services.

International Linkages with SEWA Health Co-operative

SEWA-UNFPA-GOI Partnership: Mobile Health Clinics

The SEWA-UNFPA-GOI partnership has enabled SEWA to conduct various mobile health clinics such as paediatrics, eye, gynaecological, and general health. These health clinics are held where there is a perceived need for specific health services. The CHWs assess the health needs of the various communities. Mobile health clinics are organised in such a way that there is optimum use of health resources. They are held in a central location so that individuals from four or five slums or villages are able to access the services. Local physicians and health care workers are part of the health care provision, which fosters a sense of familiarity between them and the community members. The CHWs inform people of the location, time, and type of health clinics to be held, and encourage those who need the services to utilise them. Individuals who are unable to go because of financial constraints are assisted with their payment by the CHWs, with the understanding that they will reimburse them at a later date. Another way that the CHWs ensure that people access the services of the health camps is to reserve vehicles from SEWA to fetch those who live in remote areas. The CHWs are responsible for ensuring that those who require follow-ups do so and prepare the reports with the help of their supervisors and the health researchers regarding the outcome of the mobile health clinics.

WHO-SEWA Link: TB Clinics

SEWA's past health work in tuberculosis (TB) and the success of its grassroots networks led to its link with the World Health Organisation (WHO) to address TB. The SEWA-WHO collaboration has enabled it to manage two TB clinics. At these clinics SEWA health workers, laboratory technicians, and TB coordinator manage the work that ranges from sputum collection, conducting sputum smear tests, to dispensing medications under the Directly Observed Treatment Short-course (DOTS) method. In addition to their clinic work, the CHWs travel to various slums to ensure that clients take their TB medications under the DOTS system. There is a further plan to operate another TB clinic in the district of Kheda.

A Shift in Health Work: Connecting With Male Members

SEWA continues to be a women's organisation. Its experiences in labour work within Gujarat's socioeconomic structures show that women are reticent to speak in men's presence. Their reticence stems from their socialisation in a patriarchal society that continues to silence women. Thus SEWA will continue to remain a woman's organisation because it

> believ[es] that if men were admitted, they will simply take over and SEWA's purpose would be lost. Also, a woman's participation in an all-women's organization is more easily accepted by her extended family than it would be in a mixed forum. (Rose, 1992, p. 88)

In addition, an all-female organisation provides other women with the ideal setting for role models. However, some SEWA women have approached the health team for the inclusion of males in health training. These women understand that in a patriarchal society, the power of control lies in the hands of men. To initiate changes to benefit women, males have to be educated regarding various health issues. The goal is to educate a core group of men so that they can reach out to other males in the community and sensitise them to women's health. Currently, two senior SEWA female health supervisors are doing the pioneering work in men's health education. Sixty males who are SEWA members' husbands, brothers, and sons are part of this health education. Other topics that will be dealt with in future are HIV/AIDS and the impact of alcohol and tobacco consumption on self and on the family. Although health education and work may overlap, the male group will remain separate from the SEWA organisation, and these men may in time form their own association.

Dais and SEWA Health Co-operative: Observing the HFA and RCH Link

The Health Co-operative's initiatives focus on two broad objectives: work and income generation. Capacity building and good health are fulfilled when women achieve these objectives. Although steady work and regular income are vital to women for their daily existence, it is the learning and acquiring of different skills that give women the confidence to move forward. Women of SEWA, who are generally perceived to be incapable of achieving both, have proven that this is not the case. If presented with opportunities, they are capable of initiating changes and learning new skills and knowledge. Within this context, *Dai*s' work fits well within SEWA's mission of equipping them with skills that would propel them forward economically and socially.

There are three reasons why SEWA's work with *Dai*s is worth exploring. First, the organisation's work with the *Dai*s provides a unique example of how a group of women who are hampered by their inability to read and write have been taught new skills and knowledge. This is a shift from the previous belief that literacy is essential for *Dai*s to understand the importance of delivering safe care and learning new knowledge. Second, SEWA has shown that it is possible to implement an alternative economic framework to address the work and income issues of a marginalised population. Third, SEWA's (1997-1998) baseline health survey shows that women's precarious health is affected during childbirth and that they are vulnerable to small shifts in their health status. The findings from this study indicate that *Dai*s' ability to provide obstetric health services is critical for women. Together the three reasons point to the fact that SEWA's involvement with *Dai*s follows the HFA and the RCH frameworks.

For example, one of the key points that the HFA makes is decentralisation of services. In this instance, the Health Co-operative's entire structure (physical and distribution of personnel) is geared to ensure that SEWA women have access to appropriate health services. From establishing small primary health centres in various parts of urban and rural Gujarat to the training of local women as community health workers (CHWs).to provide health care, the SEWA Health Co-operative has shown that the HFA framework is possible to operationalise. Involving local indigenous healers and women to provide health services is another key feature of the HFA. Again the Health Co-operative has done this at various levels from supervisors to CHWs, who in many cases are also the *Dai*s in their communities. Because of their intimate knowledge about the health needs of their communities, mobile health clinics are organised based on the *Dais*/CHWs' feedback. What SEWA Health Co-operative (and SEWA) has done is to implement a local socioeconomic framework to meet the needs of poor women and taught them to be self-reliant. The fact that SEWA's framework resembles HFA attests to the latter's universality of addressing health and health care issues. A recent review of HFA in 1997 reinforces the importance of developing each country's human resources, a similar call made by the participants at the ICPD (RCH) conference (UNFPA, 1994). They noted that for successful implementation of the RCH framework:

> Governments must give priority to investment in human resource development in their population and development strategies . . . to increase people's access to information, education, skill development, employment opportunities. . . . Existing inequities and barriers to women in the workforce should be eliminated, and women's participation in all policy-making and policy implementation should be promoted and strengthened. (p. 8)

Therefore, SEWA's involvement with *Dai*s aligns well with the RCH's and HFA's vision of human resource development. However, SEWA's approach with *Dai*s goes beyond human resource development. There is a concerted effort to address the structural barriers that prevent *Dai*s' full participation at policy levels. In addition, its goal is to ensure that *Dai*s achieve full employment and secure regular income. SEWA considers *Dai*s as essential health workers, and like most self-employed women, *Dai*s struggle to make ends meet and remain visible. SEWA's training programmes, alternative economic structures, continued efforts to link *Dai*s with mainstream health system, and ongoing lobbying reflect a long-term investment in *Dai*s.

The Health Co-operative's success lies in its ability to combine economic issues with health concerns. Through its various initiatives it has shown that women at the grassroots are capable of mobilising themselves to address health, economic, and social barriers. A good example is the programme for training CHWs. The training fulfils multiple objectives. It is an economic venture that provides women with work, a route where women learn about the importance of their health and gain confidence. At the organisational level the Health Co-operative's leadership and membership structure consists of women who ordinarily would be in the margins. Assuming a leadership role means that women learn the art of negotiating and articulating issues in a secure environment. Similarly, the *Dai* co-operatives provide a safe, formal setting for informal education about leadership, negotiating and developing policies, and learning to control and market their services.

SEWA leaders believe that once women gain economic independence and security, they will be able to address other social barriers that impact their health. This is evident in the way that women have articulated their readiness to educate male members of their communities about health and, in doing so, address the cultural and social barriers that impact them negatively.

At all levels, from the grassroots to leadership, SEWA Health Co-operative (and SEWA) has demonstrated over and over again that poor and marginalised women should not be written off. The co-operative's work with *Dais* provides a good case study of strategies to empower women. More important, the co-operative's initiatives illustrate that the RCH framework, similar to that of the HFA, could be implemented. Through its innovative work, SEWA Health Co-operative has presented opportunities for education, skill development, and employment to *Dais*. It has also provided *Dais* with a forum to work on policies within both the SEWA organisation and their own co-operatives. SEWA's work with *Dais* is a good example for the Gujarat government to emulate to address the health of a vulnerable population and ensure that health care is accessible. After all, SEWA and its members do not exist in a vacuum but within the overall societal structure. For all these reasons, SEWA's work with *Dais* is worth exploring if the Gujarat government wants to implement the RCH framework successfully.

SEWA Health Co-operative and Dais

Organising Dais Through Training

Dai training is more than imparting knowledge, although this is one of the objectives. Training is a strategy that SEWA uses to organise and mobilise the *Dais* to promote self-reliance, empowerment, secure income, and employment. Apart from the fact that it shows that *Dais* are capable of learning new skills and knowledge, the training is also about legitimising their position as health workers. According to SEWA, additional knowledge would bolster the *Dais*' position and enhance their image as professionals. The ultimate goal is to enable *Dais* to provide safe delivery care, have regular employment and income, and gain a feeling of self-worth.

In 1991 the Foundation for Public Interest (FPI) conducted a survey in Gandhinagar and found that 70% of the deliveries were conducted by the *Dais* (Mirai Chatterjee, personal communication, December and January, 1999-2000). Mirai[52] estimated that in remote areas of Banaskantha, 95% of the deliveries are in the hands of the *Dai*s. SEWA also found that many of their women members would access the *Dai*s instead of the doctors because of cost. Based on these statistics and the fact that *Dai*s are some of the poorest and most socially marginalised women because of their low castes, SEWA decided to organise them (Mirai Chatterjee, personal communication, December and January 1999-2000).

The above study provided evidence of the *Dai*s' contributions to health care. One of the first steps that SEWA took was to enlist the help of the trainers at the State Institute of Health and Family Welfare (SIHFW)[53] to provide training for the *Dai*s. The *Dai*s were given biomedical training over a period of six months for two days per month. The topics included women's and children's health, nutrition, immunisations, signs and symptoms of complicated pregnancy and delivery, gynaecological diseases, and steps for conducting safe and clean deliveries. The exam was conducted orally through questions and answers.

The goal was to make them visible and upgrade their skills so that they would be confident and accepted as the 'trained *Dai*s' by the biomedical establishment. However, the result of this training was mixed because two or three of the *Dai*s were employed in the formal health sector in the Primary Health Centres (PHCs) and moved away from the community. Although formal linkages were the original goal of SEWA, nevertheless, SEWA attempted to organise *Dai*s from other districts to receive similar training from the SIHFW. In the end, because of budget constraints, this was not carried out. Thus SEWA decided to train these women on its own while at the same time continuing to link with the mainstream health system.[54] SEWA's training[55] was again related to the economic and work security of the *Dai*s. It decided to integrate the primary health care component so that the *Dai*s would not be limited to conducting only deliveries but would also be able to work as community healers.

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[52] Mirai Chatterjee was the general-secretary (1996-1999). She joined SEWA in 1984. Her background is in public health. She is currently the chair of *Lok Swasthya* Health Co-operative and oversees work in insurance, health, and childcare of SEWA members and is also the coordinator of SEWA's Social Security Team.

[53] This is the main training centre for health for the entire state of Gujarat.

[54] *Dai*s were introduced either to the various biomedical health workers of the Primary Health Centres (PHCs) or to municipal hospitals in Ahmedabad City. In addition, SEWA also works with private gynaecologists to provide refresher courses to their *Dai*s and the CHWs.

[55] Mindful of women's other work and the demands on their time, SEWA's training was over a period of two years for two days a month.

To ensure that SEWA *Dai*s received the same information as those who were trained by government trainers and received the same form of recognition, the SEWA Health Co-operative organised *Dai*s en masse from Ahmedabad District to receive the training from the staff and trainers of Bavla PHC (in reality it appeared to be a refresher course rather than training, Bavla PHC, April 1-3, 1999). After this three-day session, the Gujarat health ministry issued identity cards to the *Dai*s who participated.

The training of the *Dai*s as a mobilising strategy is linked to the 10 points that SEWA formulated to guide its work with self-employed women. The ultimate goal is for *Dai*s to achieve regular incomes and steady employment, ensure adequate nutritional intake, and increase their assets and their organisational strengths. However, this would happen only if the broader society were to view them as legitimate workers and professionals. This is why SEWA established a *Dai* School.

Establishing a Dai School

In March 2000 the SEWA *Dai* School came into being. At the outset, the setting up of a school may not appear to be an innovative venture, but for the *Dai*s it has widespread ramifications. At one level the presence of an institution reinforces their position in the health system, legitimises their contributions, and is a symbol of permanence, unlike the government's vision of the *Dai*s as temporary. Formal training with a set curriculum and certification places the *Dai*s at the same level as the other trained health care workers. Taken together, these have the potential to correct negative perceptions of *Dai*s and their work. SEWA's goal to build the *Dai*s' capacities and their scope of practice is linked to other long-term objectives, such as the ability to create multiple economic niches to earn income, to build their confidence, and, one day, to be able to negotiate with state officials. Thus SEWA's work with the *Dai*s shows that alternative methods are needed to mobilise women who are in the margins.

The first group of 'trainee' *Dai*s was from Ahmedabad District. They were the pilot-test group. Based on the evaluations of this group, the training syllabus would be modified. During the planning stage of the school, SEWA invited the past director of the SIHFW, SEWA's founder Ela Bhatt, SEWA administrators and leaders, potential trainers, members of the SEWA health team, and representatives either from each district or from each *Dai* co-operative to a meeting. This meeting provided a forum for those who were present to provide input for the content and the management of the school. The representatives were then asked to bring the issues that arose during the first meeting back to their members to receive their feedback. The first intake of *Dai* trainees was in March 2000. During the planning stage it was agreed that the school hours would depend on the *Dai*s' workload and availability, because many of them are agricultural labourers. According to the Concept Paper, the objectives of the *Dai* School were (a) to identify *Dai*s and organise them into their own organisations to increase their visibility, (b) to enhance their knowledge and midwifery skills, (c) to increase their knowledge base in primary health care; and (d) to build linkages with government and private health care providers (Chatterjee, 1999, p. 1).[56] The goal of these objectives was to assist *Dai*s' to achieve their goal of self-employment.

Although SEWA contended that the *Dai* School would have a beneficial effect on the *Dai*s, the real impact will remain unclear until an evaluation is done. SEWA plans to conduct this three years after the opening of the school (Chatterjee, 1999). But what is clear is that by operating a school for *Dai*s, SEWA is conveying a message that women in the margins are able to better their social and economic situations if they are given the opportunity. As noted, SEWA focusses on women's capabilities, and this approach contrasts with that of the state governments and other international agencies.

Identity Cards

The issuance of identity cards[57] is another strategy that SEWA has tried to increase the *Dai*s' visibility. The identity cards were given to SEWA *Dai*s after they had completed the training. The card formally recognised and legitimised their skills (Mirai Chatterjee, personal communication, December and January, 1999-2000).[58] On October 2, 1998, the Health Minister,

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[56] There exist two concept papers, one of which was written by Mirai and the other by Dr. Kamal Naik. The latter is actually a formal proposal. I refer to Mirai's concept paper because it aligns closely with SEWA's philosophy about women's work and income.

[57] The SEWA Health Co-operative adopted this idea from SEWA *bidi* workers.

[58] Although to what extent this legitimacy had changed from the previous standing is unclear. SEWA had not conducted any research. I did ask the SEWA and non-SEWA *Dais*, and they said that the card was acknowledgement that their work was recognised by SEWA and the government (issued by the health ministry), which was important. They felt included in the system (PhD fieldwork, 1999-2000).

Ashok Bhatt, officially announced that *Dai*s throughout the state would receive identity cards, skill upgrading, and increased remuneration from the government.[59]

Dai Co-operatives

During my fieldwork there were three *Dai* co-operatives and one in the process of being registered as a co-operative (in Mehsana). The co-operatives have the dual role of economic unit and social group. SEWA is working with the health ministry of Gujarat and other NGOs to highlight *Dai*s' social and economic contributions to the state. SEWA Annual Report (1997) noted:

> *Dai*s or traditional birth attendants (TBAs) have been conducting home deliveries in Gujarat's villages for centuries. They also provide general primary services to families. Yet they remain unrecognised by the government's Health Department and society in general. They neither get the respect that is their due nor do they play any significant role in the government health system. SEWA has been demanding that the *Dai*s be registered, given identity cards and be given responsibility for providing decentralised health care at women's doorsteps in the villages. (p. 12)

The goal of the *Dai* co-operatives aligns well with SEWA's overall vision of self-reliance and sustainability for women. It provides women with opportunities to organise themselves as a collective so that they can promote their interests at various societal levels. As a collective they will be able either to articulate their demands to the government or to solicit the support of the people. Through the co-operatives, SEWA hopes that the *Dai*s will achieve some form of steady self-employment. In doing so, they will be able to promote their own development through either networking or policy changes.

Future Directions of the Health Co-operative

The Three-Day Meeting at Manipur (January 2000)

The three-day meeting provided members of the various health co-operatives, SEWA members, and leaders the opportunity to learn about SEWA's health work. The meeting became a forum for reevaluating past work, revisiting past goals, and planning future health work based on members' health needs and concerns within the framework of SEWA philosophy. Future directions were mapped for the Health Co-operative from the inputs of those present during the meeting.

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[59] It was decided that the *Dai*s would receive Rs. 20 (an increase from Rs. 10) for each normal delivery and Rs. 50 for referring each at-risk pregnancy and delivery.

SEWA has expanded since its humble beginnings in 1972. As the membership becomes 'sophisticated' and informed, the Health Co-operative anticipates that the demand for more quality services will increase (SEWA, 2000). Through its health work, SEWA has attempted to keep members in touch with the changes that are occurring beyond their immediate environment, one of which is the effects of globalisation. The international linkages established with SEWA and the various health policies, notably RCH, show women that they are part of a larger system that is both local and international.

The shift is also visible in SEWA's current leadership. These leaders, from middle-class background, possess tertiary education from either the local universities or overseas. They are different from the original leaders. These new leaders are politically astute and are able to articulate in languages that are understood by the international agencies, funders, and government officials. At the same time these women speak the language of SEWA members. The smooth and seamless transition of leadership has been due to the foresight of Ela Bhatt. Ms. Bhatt personifies the rare quality of a leader who understands that for SEWA to sustain itself, it must evolve with the changing times while continuing to meet the needs of poor women. To do this, the organisation must be in touch with the realities of poor women and those of the outside world. Therefore, SEWA must have leaders who are able to meet these requirements. Although Ms. Bhatt is consulted on important issues that could affect SEWA (as in the establishment of the *Dai* School), the day-to-day management is in the hands of the women who have been elected to the Executive Committee. This has ensured that SEWA is in the hands of the second-generation leaders who have the training and the experience to take the organisation into the next millennium.

The three-day meeting re-established and reinforced the interconnectedness of the Health Co-operative's work with the rest of SEWA. It was to remind everyone that SEWA exists because of the poor self-employed women and that all work must lead to the improvement in their lives. The aim is to push for self-reliance and sustainable development through local social, economic, and health initiatives.

Conclusion

SEWA's success in formulating and implementing its various health programmes, and other economic and social initiatives, shows that health is indeed a multisectoral effort and that good health results when these sectors intersect. Thus each of its economic endeavours has a health component and vice versa. The organisation recognises that all are closely interwoven and integral to women's health. In addition, the organisation's success originates in the basic philosophy that poor women are capable of articulating their health needs and seeking solutions when opportunities and choices are available. In this regard SEWA has, with the co-operation of its members, formulated a number of strategies to address their socioeconomic needs and build their capacities. For the *Dais*, SEWA's strategies include providing them with training, opening a *Dai* School, issuing ID cards, and setting up co-operatives.

Training and co-operatives encompass the ideals of both union work and professional boundary. SEWA understands that *Dais* need to undergo a change of image to remove the stereotypes in order to gain power and legitimacy within the formal health structure. By establishing a formal training school along the lines of those for other health care professionals with set curriculum, the organisation has achieved two objectives. It ensures that *Dais* are well equipped to deliver health care beyond delivery services and that there is a benchmark to measure their competencies. The other objective is to strengthen their bargaining power because they occupy multiple economic niches. However, training has the potential to marginalise *Dais*. It could mean the beginning of the end of their indigenous knowledge once they assimilate into the formal structure because *Dais'* new knowledge must be a good fit with that of other health workers. This is to ensure that all 'speak the same health language.' *Dais* would then be governed by the same hierarchical rules, likely placing them at the bottom of the hierarchy. In addition, there is also a potential for *Dais* to become inaccessible once they adhere strictly to their profession's rules, job description, and fees. On the whole, SEWA's initiatives benefit *Dais*, but tension could arise between the *Dais'* need for income and work security and the needs of the community. Therefore SEWA and *Dais* have to be cognisant of the potential disadvantages of training and co-operatives.

CHAPTER 5

INDIGENOUS MIDWIVES AND WORK

Introduction

This chapter reviews the literature on indigenous midwives around the world and in India, and the literature on work. It begins with a general overview of midwives around the world, followed by a profile of indigenous midwives in India. The section on midwives in India focusses on the unique issues experienced by them; therefore commonalties among Indian midwives and midwives in other parts of the world are stated at the beginning. A review about work, with a particular emphasis on home-based, informal work, follows immediately because understanding the nature of work is critical to understanding midwives' work. A literature review about indigenous midwives (in India and the world) and their work would be incomplete without discussing the impact of training on their practice, and therefore this is also included. Gaps in the literature are highlighted in the conclusion.

The Indigenous Midwives (TBAs)[60] Around the World

Profile of Indigenous Midwives

Although most literature identifies these women as traditional birth attendants (TBAs), I believe that the term *indigenous midwives* describes them well because it does not have the value-laden connotations of a "TBA."[61] This belief reflects my stance that the word *traditional* does injustice to the midwives' efforts to adapt and upgrade themselves. In addition, *traditional* devalues their accumulated knowledge and portrays it as monolithic and static, whereas knowledge is continuously created, discarded, and revised. *Traditional* provides a convenient opposite to science's modernity and subsequent power to determine which knowledge and work are considered valid and legitimate.

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[60] In my own writing I will use *indigenous midwives* instead of *TBAs*, but when citing quotations from the literature, I will follow the author's terms.

[61] Brigitte Jordan (1978/1993) has done similar renaming of TBAs in her *Birth in Four Cultures* after being advised by Carol McCormack. I follow Dr. Jordan's example and give reasons.

Indigenous midwives are universal figures (Cabral et al., 1992a, 1992b). They[62] are found in Africa (Brink, 1982; Buchman, Kritzinger, Tembre, & Berry, 1989; Daly & Pollard, 1990; Duale, 1992; Eades, Brace, Osei, & LaGuardia, 1993; Elujoba, 1995; Jepson & MacDonald, 1988; Kwast, 1988; Larston, Sodpe, Ebrahim, & Abel, 1987; Lynch & Derveeuw, 1994; Menendez et al., 1993; McLean, 1997; Solomon & Rogo, 1989; Stanley, 1997), Asia (Bashir, Aleem, & Mustanar, 1995; Bolam et al., 1998; Chen, 1973; Chonsuvivatwong, Bucharkorn, & Treetrong, 1991; Pillsbury, 1978, 1982; Rozario, 1992, 1995, 1996, 1998; Sich, 1988), the Middle East (Bakker, 1992; Scheepers, 1991), Mexico and South America (Camey et al., 1996; Dalle, 1997; Janowitz, Bailey, Dominik, & Araujo, 1988; Jordan, 1989, 1993; O'Rourke, 1995), Australasia (Jenkins, 1984; Mitchell & Mackerras, 1995), North America, and Europe (lay midwife/granny midwife; Barry & Boyle, 1996; Butter & Kay, 1990; Logan, 1991; Qinuajuak, 1997; Smith, 1997; Smith & Holmes, 1995). The WHO/UNICEF/UNFPA (henceforth WHO, 1992) recognised varieties of TBA. WHO noted that

> a **traditional birth attendant** (TBA) is a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants. A **family TBA** is a TBA who has been designated by an extended family to attend births in that family. A **trained TBA** is a TBA or a family TBA who has received a short course of training through a modern health care sector to upgrade her skills. The period of actual training is normally not more than one month, although this may be spread over a longer time. TBAs who undergo extensive training (six months to one year) are then often employed as primary health care workers. They may continue to function as TBAs, delivering babies in their community when asked. (p. 4)

According to Cabral et al. (1992b), indigenous midwives fulfill a vital community need by assisting pregnant women during their labour, delivery, and the immediate postpartum period. The authors estimated that each year midwives around the world provide midwifery services and immediate care to about 75 million mothers and their infants, and they probably conduct up to 95% of the rural births and 70% of the urban births in the South (Cabral et al., 1992b).

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[62] Although in many societies the indigenous midwives are females, there are some communities—for example, among certain tribal groups in Gujarat—where the indigenous midwife could also be a male (Smita Bajpai, personal communication, September 1999). Lefeber and Voorhoeve (1998) noted that male midwives are found in other cultures such as the Philippines, Ghana, Indonesia, Bolivia, and so on, but they usually work as herbalists to provide treatment for complications of pregnancy and birth. In this research I identify the indigenous midwife as a female for two reasons: First, most of the literature has shown that they are women; and second, the samples in my research are all female *Dai*s. In doing so, I am not negating the contributions or the role of male midwives, but I feel that they deserve focus as a unique group of individuals whose work and contributions cannot be extrapolated from those of the female midwives. It requires separate study and discussion that is beyond the scope of this dissertation.

Indigenous midwives are usually residents of the communities; however, they also travel to other communities to provide care. As residents of their communities, they are familiar with the social code of proper behaviour and the beliefs and rituals surrounding conception and delivery. They are culturally accessible and acceptable to people. Their status and acceptance, however, are closely linked to the social markers. For example, they may be respected because of their age, knowledge, and experience; but these attributes may be superseded by other social mores and the way birth is perceived. Rozario (1992, 1995, 1998) and Jeffery, Jeffery, and Lyon, (1989) noted that the indigenous midwives in Bangladesh and India are not highly regarded because they are usually from the lower castes, who perform ritually polluting work. Midwives are accepted because they are the mediators between the mother and the polluted substances, which other family members do not want to touch. Although this can be perceived as covert power because the midwives occupy a niche, in reality these women are tolerated because of what they are willing to do that others prefer not to do. Walt (1984) thus cautioned against statements such as that indigenous midwives are "always 'acceptable' to the community" because she noted that "it may be correct, but may also be simplistic. They may be recognized as having useful functions, but may not carry the authority to persuade women to change practices, or to attend ante-natal clinics, etc." (p. 6).

Another common, accepted belief in the context of birth and labour is the perception that births should be assisted. For example, the culture of the Angal Heneng of the Southern Highlands of Papua New Guinea shows that this belief and practice may not be universal. Furthermore, similar issues related to births may not be dealt with or interpreted the same way among cultures. A case in point is the way untouchability and pollution are interpreted and dealt with by the Angal Heneng and peoples of South Asia. The Angal Heneng believe in the cultural concepts of contamination and pollution of birth (Alto, Albu, & Irabo, 1991). In fact, in their society the role of an indigenous midwife does not exist. Women in this group are expected to deliver alone in a hut, separately from the actual house. The Angal Heneng believe that contact with a woman's blood during birth is dangerous and could lead to illness and even death. Village women are not allowed to assist a labouring woman due to fear of contamination. Furthermore, discussions regarding conception are taboo not only between men and women but also amongst women themselves (Alto et al., 1991). But studies done in other parts of the world—for example, Jordan's (1978/1993) research in the Yucatan and Dalle's (1997) research in Honduras—show that the indigenous midwives are indeed respected and held in high esteem by the people. The concepts of pollution and untouchability do not appear to be an issue.

Indigenous midwives may occupy a well-defined role in the community or conduct deliveries within their own families. Either way, they are individuals who help other women in the course of their pregnancies and labour. In many societies indigenous perceptions of childbirth differ from the biomedical orientation. In the former, childbirth is perceived as part and parcel of life, a rite of passage[63] that enables the adult individual to assume a parental role with a set of obligations and responsibilities. These obligations then connect the new parent and the child to a larger community with new relationships. Consequently, people do not consider childbirth or pregnancy as medical conditions.[64] For these individuals a doctor or a nurse is called upon only when there is an illness (and even then not until they have exhausted all indigenous or lay health-promoting and curative measures), and pregnancy and childbirth are not illnesses. Indigenous midwives therefore perceive their role as facilitators of ritual passage of birth.

The literature portrayed these midwives as respected members of their communities; however, this respect is not universal. Nessa (1995), for example, described the indigenous midwives of Bangladesh as ignorant, and Kamal (1992) noted that in Pakistan they are perceived as "dirty, stupid, illiterate and ignorant" (p. S55). By contrast, WHO (1992) stated that "TBAs are generally wise, intelligent women, . . . have dynamic personalities and are accepted figures of authority in the community" (p. 5); or they are of "high social standing, . . . exerting considerable influence" (WHO, 1978, p. 63). To summarise the literature, indigenous midwives are usually older women who are married or widowed and who have experienced childbirth and accumulated their knowledge through these events, and who are geographically, culturally, and economically accessible to other women. Because of their knowledge and expertise, they are then called upon to care for other women or provide advice to ensure that labour proceeds smoothly and that all the rituals are observed for the well-being of the mother and child.

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[63] Van Gennep (1909/1960) coined the term *rite de passage* to explain how society accommodates individuals and ensures its continuity. Rite of passage consists of separation, liminality, and re-aggregation; and the various phases ensure that individuals learn the correct mode of behaviour for the continuation of the society.

[64] However, in her study, *Birth as an American Rite of Passage*, Davis-Floyd (1992) showed that women do perceive their experiences of pregnancy and childbirth as their personal rite of passage even if the medical personnel may not. Medical training in itself is a rite of passage when a novice enters medical school and graduates as physician (Davis-Floyd, 1987).

The midwives learn either from their own female relatives (mother, mother-in-law, sister-in-law, aunts, etc.) or from another midwife in their own village or town. However, there are other ways that indigenous midwives acquire their knowledge. Some of the midwives mentioned that they had learned about delivery and begun to work as a midwife after experiencing their own labour, whereas for others it was a vision, a divine calling, or an inner calling that led them to become a midwife (Lefeber & Voorhoeve, 1998). Then there are those who were taught either by private physicians or by public health nurses at a clinic/hospital where these midwives lived (Jordan, 1993; Lefeber & Voorhoeve, 1998; McLean, 1997). The common themes underlying these narratives are that midwives feel that it is their duty or calling to help women in labour, which begins after they themselves have children of their own. This is in direct contrast to the biomedical system in which the practice of midwifery is dependent on the level of specialised knowledge, not on marital status or fecundity; the entry into midwifery, however, is based on certain minimum qualifications and age (Turkel, 1995). The indigenous system, on the other hand, uses social status to control the entry of practice, although learning could begin at an early age through events of daily living and later through apprenticeships (Jordan, 1993; Lefeber & Voorhoeve, 1998; Logan, 1991; Smith & Holmes, 1996).

The literature described these women as illiterate, unable to either read or write or both. However, if the definition of literacy is expanded to include the knowledge of their work (Freire, 1970, 1988; UNFPA, 1994), then these midwives are literate.[65] Many of them are skilled in the healing of conditions aside from childbirth. They prescribe herbal remedies for coughs and colds; female problems such as menstrual cramps, white discharge, fertility issues, abortion, and retained placenta, in addition to nutritional advice, and they perform therapeutic massage (Lefeber & Voorhoeve, 1998; Logan, 1991; Mitchell, & Mackerras, 1995; Smith & Holmes, 1996). The midwives are able to provide the logic that influences their actions and decisions in their work. For example, although some of the food taboos appear to be harmful to the health of women, the midwives in Bangladesh promote these taboos to prevent the baby in-utero from becoming too big (Nessa, 1995). The reason is to avoid a difficult labour. Not only do these 'illiterate' women connect the growth of the baby in-utero to the type of food intake, but also their concern to avert a difficult labour is a valid one (Nessa, 1995). Health care centres are either poorly equipped or are far away, and the midwives are usually the only individuals who manage these births because these facilities are inaccessible and the woman's family is reluctant to take her to the hospital due to the high costs of transportation and treatment involved (Nessa, 1995). Chowdhury (1998) and Nessa noted that in an agrarian country such as Bangladesh where 80% of the population live in the villages, "where trained hands for maternity services are non-existent, TBAs are the only persons who can offer a modicum of help during childbirth" (Nessa, 1995, p. S135). In this environment the 'illiterate' midwives' 'harmful' knowledge and practice become logical and appropriate and appear harmful only when taken out of the local health and cultural contexts.

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[65] The participants at the ICPD (UNFPA, 1994) acknowledged the role of informal learning.

Delivery work is but one task that indigenous midwives perform. To augment their income they work as agricultural labourers, daily wage earners, petty traders, houseworkers, or handicraft workers. And unlike biomedical practitioners who demand payment in cash, these midwives accept payment in-kind, cash, and sometimes not at all if the family is too poor to pay (Logan, 1991; Smith & Holmes, 1996). This is related to the belief that they are doing a service and that payment should not be a factor. Thus midwives build relationships of reciprocity and behave in a manner that is appropriate within the social fabric (Buchman et al., 1989; Elujoba, 1995; Jeffery et al., 1989; Lefeber & Voorhoeve, 1998; Mangay-Maglacas & Pizurki, 1981; Prendville, 1998; Walt, 1984). The WHO (1992) noted that "usually their compensation includes favoured status in the community" (p. 5). Again, as indicated above, this status is dependent on the cultural contexts of the midwives. Indigenous midwives in South Asia are generally not accorded favoured status.

Indigenous midwives perform an important function of bridging and meeting the shortfall of basic health care facilities and services. Brink (1982) noted that the Western-trained community health nurses in the Abak Local Government Area in Nigeria could not handle the volume of deliveries if there were no indigenous midwives to do some of them. Thus by referring only difficult cases to the nurses, the health care system was able to meet the demands. Other authors in other parts of the world have observed the integral role of the indigenous midwives within the health care system (Chowdhury, 1998; Kwast, 1988; Stanley, 1997; Troskie, 1997). The WHO (1992) noted that one of the goals of training TBAs is "to bridge the gap until all women and children have access to acceptable, professional, modern health care services" (p. 2). Notwithstanding this usefulness of meeting the needs of women due to the shortfall of modern health care (Mangay-Maglacas & Pizurki, 1981; Verderese & Turnbull, 1975; Walt, 1984; WHO, 1992), the literature also indicated that midwives are integral in promoting the understanding of indigenous health. The work of these attendants shows that birth is a cultural and political event and not merely a biological one. Through their work they assist in perpetuation of the social structures, rituals, and beliefs that support the economic and political base. Thus the joint statement on TBA indicated that

> in any event, there will always be a need to keep what is best in TBA care: the sense of caring, the human approach, and the response to cultural and spiritual needs. For a long time to come, even when women have access to modern health care and the services of a professional midwife or physician, they will also seek the care of the traditional healers and birth attendants for advice and complementary care. (WHO, 1992, p. 17)

Dais in India

> The *dai* is India's traditional midwife, also known as a *dai-maa* in hindi, *daayan* in gujarati, *suin* in marathi, *pathichhi* in Malayalam. . . . The word *dai* stems from *daayi* meaning 'one who gives.' [Interestingly], it is akin to *daakin*, *daain*, *daakan*—meaning witch. (Bajpai, 1996, p. 83)

The *Dai*s in India have socioeconomic characteristics similar to those of indigenous midwives in many other parts of the world (Bajpai, 1996; Banerjee, 1990; Bang, Bang, Sontakke, & Search Team, 1994; Bhardwaj, 1993; Campbell, 1990; Chaturvedi, 1978; CHETNA, 2000; Choudhry, 1997; Dutta, Bhandari, & Bhandari, 1983; Gupta, 1978; Iyengar & Bhakoo, 1991; Jeffery et al., 1989; Kamal, 1992; Kambo et al., 1994; Krishna, Naidu, & Rao, 1984; Kumar, 1995; Kumar, 1983; Kumar & Datta, 1988; Kumar & Walia, 1981, 1986; Mani, 1980; Mathur et al., 1979; Mathur et al., 1983; Mulder, 1995; Raina, & Kumar, 1989; Singh, 1994; Stephens, 1992; Swaminathan et al., 1986; Walia, 1986, 1994; Wasan, 1982). Thus their age, marital status, mode of learning, residence, work and knowledge, and compensation are similar to those described above. However, unlike the midwives in other countries, the *Dai*s in India have to contend with the religious and social concepts of birth pollution and the caste system. In understanding these connotations, the social and economic position and practices of the *Dais* become clear. Authors have noted that the *Dai* is perceived of as "unhygienic, backward in thought and dangerous in her practices" (Smith, 1998, p. 49) or as "a necessary evil," "having poor skills," "being incorrigibly 'superstitious'" and having "unhygienic practices" (Mulder, 1995, p. 24).

Jeffery et al. (1989) and others (Mulder, 1995; Smith, 1998; Walia, 1986) described *Dais*' ambivalence towards their work. Although *Dais* "provide warm and womanly care to most women in rural areas" (Bajpai, 1996, p. 84), they also perform the defiling and dirty work of birth according to cultural perception. Jeffery et al. (1989) noted that childbirth pollution is the most severe of all pollutions, much more than menstruation, sexual intercourse, defecation, and death. The cutting of the cord, the delivery of the placenta, and the cleaning of the afterbirth are all considered to be dirty, as is performing vaginal examinations during labour. *Dais* also clean up other bodily fluids that are considered polluting.

The *Dais* are usually from the lower castes such as Chamar, Bhangi,[66] and other Scheduled Castes and Tribes.[67] Operating under these social and cultural parameters, it is no wonder that they feel inferior and ambivalent towards their work. Because of their ambivalence, the relationship between the woman's family and the *Dai* is usually an uneasy and acrimonious one, especially in the arena of payment and recognition. Most women who work as *Dai*s do so out of economic necessity, although this seems to differ from region to region. Jeffery et al. (1989) observed that the *Dai*s themselves and their families use rhetoric that describes their inferior social status and nature of work. For example, one *Dai* said, "How can I think this work is good or bad since I do it out of necessity? I have to do it. I have no education, so there is no other work I could do"; and a *Dai*'s daughter-in-law noted that there is "disgust at the *dai's* hands" (pp. 65-66). Thus the authors concluded:

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[66] The caste system is a complex structure based on the *Jajmani* system, where trades and work have been prescribed and passed down from generation to generation. So ingrained is this system that the surnames of individuals in each of the castes and subcastes further indicate their work and trades. The caste system is independent of the economic level. In most discussions the four main caste groups identified are the Brahmans, Kshatriyas, Vaishyas, and the Sudras. It is believed that these caste groups emerged from the different body parts of the Brahma, the god of creation. Thus the Brahman emerged from the mouth and the head, the Kshatriyas from the arms, the Vaishyas from the thighs, and the Sudras from the feet (Mulder, 1995). Below these castes are the Untouchables, whom Gandhi named *Harijans* or 'Children of God.' Untouchability was abolished by the Constitution; however, in everyday life it persists. Although the caste system may appear to be static, the work of the Indian sociologist M. N. Srinivasan has shown otherwise. He noted that over generations certain castes have emulated the social and religious customs of the higher castes, thus coining the word *Sanskritisation*. A *Bhangi* is a sweeper and clears the night soil, and a *Chamar* is a leather worker.

[67] The Government of India has identified certain castes as socially and economically backward, and recognising the need to protect them from social injustice and all forms of exploitation, the Constitution of India has conferred on them special protection. The term *Scheduled Caste* was used for these caste groups for the first time in India in the Government of India Act of 1935. The list of scheduled castes used in the 1991 Census was based on the Scheduled Castes and Scheduled Tribes Orders (amendment) Act of 1976 (Central Act 108 of 1976). Scheduled Castes refers to such caste, races, or tribes, or parts of groups, within such castes, races, or tribes as are declared to be scheduled castes by the President of India by public notification (Office of Registrar General and Census Commissioner, 1984a cited in the NHFS, 1993).

> Consequently it is inappropriate to regard the dai as an expert midwife in the contemporary Western sense. Even in the absence of medically trained personnel, the dai does not have overriding control over the management of the deliveries. Nor is she a sisterly and supportive equal. Rather, she is a low status menial necessary for removing defilement, and her lowly status is reflected in several ways. (p. 108)

Jeffery et al. (1989) have observed the lack of respect towards the *Dai*s in Uttar Pradesh (UP). This low regard supports Walt's (1984) caution against making statements such as that the indigenous midwives wield powerful influence in their communities and are well respected. In this situation it seems that women work as *Dai*s due to economic necessity. In contrast, the reasons that women give for working as *Dai*s differ in Tamil Nadu. Mulder (1995) found that in Tamil Nadu the incentive to work as a *Dai* stemmed from family duty and not from financial reasons.

The literature suggested that there are regional variations in how *Dai*s' work is perceived. Smith (1998) observed that a "dai provides massage and emotional support during pregnancy" (p. 50), and Bajpai (1996) wrote that "the dai [has] become a *real* holistic practitioner" (p. 85) because she invokes the Goddess Shakti by performing symbolic rituals to facilitate birth. But she acknowledged that "in a village community, one would expect love, respect and benevolence. But poor and down-trodden by caste, tradition binds her to serve others and her work is taken for granted, without recognition or reward with sometimes scarcely more than insult" (p. 84).

The literature showed that the knowledge of indigenous midwives of India does not accord them authority, unlike midwives in other parts of the world (Jeffery et al., 1989; Mulder, 1995; Smith, 1998). Their low status, which translates into a perception of low-level expertise, means that their knowledge is also perceived as unworthy. The other reason could be that the *Dai*s' 'unique' wisdom is actually 'common knowledge.' The literature indicated that the *Dai*s are called to the scene only when the woman is already in labour. The elder female family member gauges the progress of labour and decides when to call the *Dai*. Because pregnancy and childbirth are considered to be normal rhythms of life, this knowledge of birth is available to all to explain the biological event and the underlying sociocultural and economic expectations (Campbell, 1990; Jeffery et al., 1989; Mulder, 1995; Smith, 1998). There is a common perception amongst community members that *Dai*s possess neither the specialised language nor the knowledge that accords biomedical practitioners status and prestige. For example, a woman in Jeffery et al.'s study commented that "a dai does nothing at all. She just cuts the cord and washes the zacha [new mother]" (p. 110), implying that *Dais*' work and knowledge are not expert but ordinary.

Linked to the issue of common knowledge is the concept of birth pollution and cleanliness. As noted previously, birth is perceived to be defiling and dirty. Women give birth on rags, gunny sacks, or the floor and do not consider lying on a clean cloth or area (Bajpai, 1996; Jeffery et al., 1989; Mulder, 1995; SIHFW, 1999; Smith, 1998). The pollution of birth further obviates the need to wash hands or maintain cleanliness. Only after the delivery is completed do the women and the *Dai*s bathe to ritually and physically clean themselves. Even the floor is repaired either by washing or applying fresh mud at the completion of birth (Jeffery et al., 1989).

In addition, Jeffery et al. (1989) noted that childbirth and pregnancy are actually considered matters of shame and embarrassment, which further devalues the *Dai*s' knowledge and contributions. Women usually hide their pregnancies until they are well advanced. This was clearly illustrated by Jeffery et al. In one case when a baby was delivered, the *Dai* requested a razor to cut the cord. Instead, the woman's mother-in-law gave her a sharpened reed and insisted on the cord being cut with it (Jeffery et al., 1989). Thus Bajpai (1996) noted that "the roots lie in socioeconomic and gender-based exploitation and discrimination of which deficient health services for women are a part" (p. xv). Therefore to blame the *Dai*s for the high infant and maternal mortality appears to be a one-sided argument for a problem that is multifaceted.

Work

Jumani (1987) defined *work* as "any activity to sustain oneself and earn a livelihood" (p. 251), and Waring (1988) observed that "every time I see a mother with an infant, I know I am seeing a woman at work. . . . I know that money payment is not necessary for work to be done [but] when work becomes a concept in institutionalized economics, payment enters the picture" (p. 25).

Waring's (1988) statement indicates that the definition of work is not a straightforward one because there are variations. Work could be unpaid housework or paid employment. Against these diverse opinions about work, Martens (1994) asked whether there is such a thing as "real employment." For example, paid domestic work is not perceived as real employment because society considers it to be an extension of women's housework (Martens, 1994). Thus the fact that someone is paid to do a task does not automatically constitute "real work" (Martens, 1994).

Kalpagam (1994) noted that language plays an important role in defining and valuing work. For example, in the Tamil language, words that connote valuable work have masculine endings. Few words relating to work refer to the feminine gender, suggesting a cultural silence surrounding women's work (Kalpagam, 1994). Related to language is the label *feminised work/feminisation* (Standing, 1999). Employment identified as feminised work is associated with women's domestic activities (nursing, teaching, childcare) or work that has traditionally attracted a high proportion of women. Today, feminised work has come to be identified with certain types of jobs such as temporary, casual, part-time, and self-employed[68] because the bulk of workers are women. It has certain characteristics that include: low-paid, insecure, flexible, and irregular (Beneria, 1999; Cagatay & Ozler, 1999; Gimenez, 1989; Greve, 1997; Sieh, 1997; Standing, 1999). It is often juxtaposed with employment traditionally attributed to men vis-à-vis regular, stable, unionised, and secure (Standing, 1999). However, men who work in the feminised sector experience the same marginality as women (Standing, 1999).

According to Ackerman (1999), three factors should be considered when examining work. First, work is an essential human activity, and economic process involves more than paid

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[68] Sieh (1997) gave a different point of view about self-employment. This is presented in the section on informal work.

employment. Second, work is a social process that shapes and is shaped by workers' beliefs and values. Third, work is affected by technological, political, and economic (globalisation) forces. The third factor is by far the most influential in changing the nature of work that affects men and women. With the rise of market economy, society's perception of which work is prestigious and worthy has undergone changes (Kalpagam, 1994). The exchange of goods for cash income led to dichotomies such as public/private space and producers/consumers, which devalued women's work within the households (Ackerman, 1999; Kalpagam, 1994). Ackerman and others (Beneria, 1999; Cagatay & Ozler, 1999; Chhachhi, 1999; Ghorayshi & Lebanger, 1996; Greve, 1997; ILO, 1996b, 1996c; Kalpagam, 1994; Martens, 1994; Mitter, 1994; Nanda, 2000; Nguyen, 1999; Sieh, 1997; Standing, 1999; UN, 1999) observed that globalisation has increased the segmentation and homogenisation of work where women provide cheap labour, and because of technological advancement, machines have displaced women working in low-skilled jobs. All the authors noted that the quest to increase profit and efficiency has led to work being precarious and insecure, giving rise to informal work, in which women constitute the bulk of the workforce. Despite the changing nature of work, tools to measure and define work have not kept pace. This has further devalued women's contributions (Chhachhi, 1999).

The 2001 India Census definition of work, however, shows a shift from the previous Census measurements. It recognised categories such as self-employment and noneconomic activities as work and allowed Census enumerators to describe the actual nature of work instead of merely labelling these 'nonwork' activities as unemployment (India Census, GOI, 2001).[69] The 1991 Census of India defined work as

> participation in any economically productive activity. Such participation may be physical or mental in nature. Work involves not only actual work but also effective supervision

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[69] Categories: Main worker: If worked for 6 months or more, Marginal Worker: If worked for less than 6 months, Non-Worker: If not worked at all. Q. 17: Economic activity of Main or Marginal Worker: Q. 17(i): Category of the economic activity of the Main or Marginal Worker. **For Workers in Household Industry and for other Workers only: Q. 17(ii): Occupation of the person (describe the actual work of the person). Q. 17(iii): Describe in detail the nature of industry, trade or service where the person works/ worked or of self-employment.** Q. 17(iv): Class of Worker **Q. 18: If Marginal Worker or Non-Worker, under Q. 16, record non-economic activity.** Q. 19: If Marginal Worker or Non-Worker, is the person seeking/available for work? Q. 20: Travel to place of work (for Other Workers only): Q. 20(i): Distance from residence to place of work in Kilometres Q. 20(ii): Mode of travel to place of work (population enumeration, Census of India, GOI, 2001). This information can be accessed on the Census of India web page at http://www.censusindia.net (August 2002; bold mine).

> and direction of work. It also includes unpaid work on the farm or in [a] family enterprise. (Gopalan, 1995, p. 58)

However, Gopalan (1995) noted that with the exception of cultivation, the 1991 census did not consider nonmarket activities, such as food grown for home consumption, as work. Cultivation refers to crops such as cereal, millet, sugarcane, and so on and does not include plantation crops, vegetables and flowers, or other crops under the purview of personal consumption. These crops, if grown for personal consumption, are not considered to be economic activity or work (Gopalan, 1995).

Gopalan (1995) and Kalpagam (1994) traced the gradual changes in the definition of work in the Census of India. The earliest debate in the classification of occupations began during the 1871 Population Census in India (Kalpagam, 1994). In this first Census classification, domestic work was recognised as one of the occupations. However, the statistical committee rejected this inclusion because they observed that "women and children in the family are consumers, not producers. Their comfort and support is largely the object for which men emerge in reproduction, that is, take an occupation" (Kalpagam, 1994, p. 17). Women's work continued to be excluded even though an 1881 Census Report noted that

> in India all women work; some merely at household drudgery but in the most numerous and important of all classes, 'the agricultural,' female labourers are an important part. But with the custom of early marriage, the mass of females of working age are primarily wives and whether they work in the fields or not, they have certainly to work at home. (p. 18)

In 1891 the Census removed 'wives' from workers, and instead of enumerating individuals involved in occupations, it included the category 'means of subsistence,' thereby delineating individuals as either workers or dependents (Gopalan, 1995; Kalpagam, 1994). This categorisation continued in various degrees until 1951. Gopalan noted that in 1951 economic activities of people were based on 'income' and 'dependency' concepts, whereas in 1961 work was measured based on labour and time and the addition of 'workers' and 'non-workers.' In 1971 individuals were asked what their 'main activity' was one week prior to the date of the enumeration, including seasonal work, even if they were not economically active during the enumeration. The category for 'workers' was further refined in 1981 to include main and marginal workers and whether they were seeking employment. The 1991 census included all the categories used in the 1981 enumeration but also included additional criteria such as unpaid activity on a farm or in family enterprises to capture the unpaid work by women and children in their family farms and family enterprises (Gopalan, 1995). Despite the various changes to the definition of work, women's housework and work that falls within the definition of unorganised/informal work continues to be ignored both in India and around the world (Acharya, 1996; Bhatt, 1987; Chandola, 1995; Chen, Sebstad & O'Connell, 1999; Ghorayshi & Lebanger, 1996; Gopalan, 1995; Greve, 1997; Kalpagam, 1994; Mitter, 1994; Mehra & Gammage, 1999; Nguyen, 1999; Ofreneo, 1997; SEWA Annual Reports, 1988-1998).

A UN (1999) study observed that accurate data on women's work are unavailable due to the narrow framework that defines work, causing the undervaluing of both unpaid work and work in the informal sector. The study concluded that if all forms of work were included, then women's economic participation rate would be higher than official statistics show. Women's increased entry into the labour force has not made a positive impact on their overall economic status. Nguyen (1999) noted that the increase in women's employment is indicative of continuing demand for women's labour for unskilled jobs. Moreover, whenever there is restructuring within an industry/company, it is women's work and skills that are revised and downgraded (Chhachhi, 1999; Nanda, 2000; Nguyen, 1999). Also, there is an expectation that women should continue to assume the primary responsibility for housework and childcare (Greve, 1997; Nguyen, 1999; Ofreneo, 1997; Sieh, 1997). As a result, this has affected their choices and access to better opportunities that do not complement their domestic responsibilities (ILO, 1996b, 1996c; Nguyen, 1999; UN, 1999). The increase in the quantity of jobs has not led to commensurate improvement in the quality of employment (UN, 1999). Instead, women's increased participation is the result of meeting the needs of the state and market demands (Beneria, 1999; Cagatay & Ozler, 1999; Chhachhi, 1999; Elson, 1999; Horton, 1999; Kalpagam, 1994; Mehra & Gammage, 1999; Nanda, 2000; Nguyen, 1999; Ofreneo, 1997; Standing, 1999; Tzannatos, 1999).

A WHO (2000a) fact sheet noted that women are paid 30%-40% less than men for comparable work, that only a small fraction of women in 'developing' nations hold real economic or political power, and that 70% of the 1.2 billion people living in poverty are women. Furthermore, it stated that protein-energy malnutrition is significantly higher among women in South Asia, where almost half of the world's undernourished live. Hence, work in itself does not guarantee good health. In the findings of a study, ***The Women-Trends and Statistics 1970-90***, in 1970 the value of women's unpaid housework in India was 33% of the GDP; and if this unpaid work was added to the farm work by women, the figure would be 49% of the net domestic product (Gopalan, 1995).

There are other kinds of work that do not fit the mainstream work profile that are categorised as informal work (also known as *unorganised* or *casualised* work) such as home-based work or piece work, or work that is deemed as unethical, such as bribery, robbery, or cheating. Although these unethical activities are not sanctioned by society as work, they are work nonetheless because each in itself requires planning and execution.[70] Rowbotham and Mitter (1994) observed that women's work is often presented as an aberration of the male-defined productive work. Both Ofreneo (1997) and Waring (1988, 1997) pointed out that the valuation of work based on monetary exchange has made women's other ('nonproductive') work invisible. For example, both authors noted that work that produces surplus and profit is accounted for in the economic system, but work that does not produce surplus does not. Although the labour of childbirth is work for the woman, it is not defined as work in the economic system. Thus Waring writes:

> The woman in labour—the reproducer, sustainer, and nurturer of human life—does not 'produce' anything. Similarly, all the other reproductive work that women do is widely viewed as unproductive. Growing and processing food, nurturing, educating, and running a household—all part of a complex process of *reproduction*—are unacknowledged as part of the production system. A woman who supplies such labour is not seen by economists as performing work of value. Yet the satisfaction of basic needs to sustain human society is fundamental to any economic system. By this failure to acknowledge the primacy of reproduction, the male face of economics is fatally flawed. (p. 28)

There is a tacit assumption that housework is not work and homemakers are not workers. This reasoning reinforces their dependence on men, and when women do work, it is considered to be secondary to their reproductive roles and their incomes as supplementary (Greve, 1997; Ofreneo, 1997; Sieh, 1997; Wall[illegible]1989).

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[70] I am not interested in discussing the moral and ethical underpinnings of these activities. I want to highlight that there are many types of activities that can be considered work but do not get counted in the GDP. See Waring (1988) and Wenger (1998) about the value of 'good' and 'bad' knowledge.

Volunteer work is another activity that is not considered work and is therefore not factored into the country's Gross Domestic Product (GDP; Gordon & Neal, 2000; Waring, 1988, 1997). Volunteer work performed mostly by women ranges from contributing food and services to religious institutions to being board members to caring for family members in the home, further making their contributions invisible. This aspect of work is often known as 'good/charity work.' Its value is not factored into the fiscal system to show the savings the government achieves from the unpaid work and services donated by 'nonworking' individuals (Gordon & Neal, 2000; Waring, 1988). Both Waring (1988) and Jumani (1987) argued that women as workers combine this role with their other roles; namely, wife, mother, and homemaker. Thus Jumani wrote:

> The home as a work site is a very important area of women's work. To understand the role of women as workers, it is necessary to understand the network of activities in which women are engaged. The activities of a woman as wife, mother, and homemaker are not considered work by economists, but these activities consume the time and energy of women. In fact, they often define women's priorities in their worker roles. Since three of the four roles converge around the home, the demands on woman's time in the home are many. The worker role is an equally important one, and women make a choice of whether to combine the worker role with the other three roles and work at home, or separate it from the other three roles and work outside the home. (p. 252)

Thus it seems that various categories of work can be either visible or invisible depending on the geographical location of the work and the worker, the type of work performed, and the value placed on the work. Furthermore, it seems that an activity is considered to be productive or unproductive depending on whether it is paid or unpaid, whether it is performed by a group of individuals who are labelled as workers instead of volunteers or housewives/mothers, and whether the product can be exchanged based on monetary value. Waring (1988) labelled this type of analysis as the "fixation on paid labour alone as productive," which relegates women's work such as childbirth to "an activity *of* nature rather than as interaction of a woman *with* nature . . . and [as if] women play no active or conscious part in the process" (p. 29). However, as Sieh (1997) and others (Ghorayshi & Lebanger, 1996; Greve, 1997; Martens, 1994) noted, paid activity does not automatically achieve value or prestige. It also depends on whether it is recognised as being part of the formal or informal sectors and whether it is sanctioned by society.

Work: The Informal Sector

The informal sector, just like the indigenous midwives, is found in many parts of the world.[71] These include Asia (Bangasser, 1994; Dasanayaka, 1997; Maung, 1997; Ofreneo, 1997; Rose, 1992), the Middle East (Shoushtari, 1997), Africa (Basile, 1994; Cisse, 1994; Okojie, 1996; Simard, 1996), North America and Europe (Tate, 1994b, 1994c), Australia and the South Pacific (Makasiale, 1997; Tate, 1994a), and Central and South America and Mexico (Anderfuhren, 1994; Bennholdt-Thomsen, 1996; Gonzales, 1994). The informal sector[72] is also known as the grey, shadow, underground, unorganised, or black economy (Mitter, 1994; Ofreneo, 1997; Sieh, 1997; Tate, 1994a). There is no universally accepted definition of the informal sector (Sieh, 1997). The informal sector forms a direct opposite to the formal, where *formality* is defined as falling within the framework of government regulations and mainstream economics (Chandola, 1995; Kalpagam, 1994; Mitter, 1994; Ofreneo, 1997). For Franzinetti (1994), the informal sector is one in which there is no clear distinction between the individual's personal and working space. In the Ivory Coast, the activities in the formal and informal sectors are one and the same, the only difference being the actual working conditions (Basile, 1994).

Tasks performed in the informal sector are usually identified as hidden, invisible, or ghost work because they are excluded from the national accounting of productive work (Greve, 1997; ILO, 1996b; Ofreneo, 1997; Rose, 1992; SEWA Annual Report, 1997; Tate, 1994a). As noted above, one reason for this is the absence of good definitions that reflect both the changing nature of work and different types of work. Hoq and Begum (1997) noted that in Bangladesh the economic participation of women in the subsistence economy is excluded because the definition of labour force connotes wage labour. However, the informal sector accounts for one quarter of the economies in the North and about one third in the South (Sieh, 1997). Ofreneo contended that if it were not for the informal sector, the Philippine economy would have collapsed a long time ago. The informal sector absorbs more than half of the employed people, and in 1993, 55.5% (13.6 million individuals) of the 24.4 million employed persons were working in the informal sector, 5 million of whom were women (Ofreneo, 1997). In Burkina Faso the informal sector accounts for 20% of the GDP and is a source of livelihood for approximately 80% of its economically active, urban population (Cisse, 1994). The informal sector is an outcome of massive underemployment in many parts of the world, particularly in the South (Greve, 1997). In times of economic uncertainty, the informal sector becomes the "sponge," absorbing individuals who are displaced in the formal sector, most of whom are women (Ofreneo, 1997, p. 36). For example, two thirds of the jobs lost during the restructuring of the economy of Vietnam had been women's jobs (Nguyen, 1999). For most women, their only option was to find work in the informal sector (Nguyen, 1999).

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[71] The informal work discussed is paid work. I will exclude housework even though it is informal work because it is unpaid and considered to be for personal consumption.

[72] The literature on informal sector also identified it as informal economy.

Other reasons for the presence of the informal sector include rural-urban migration, as in the case of domestic workers in Brazil and Mexico (Anderfuhren, 1994; Lazarini & Martinez, 1994), the inability of the formal sector to meet the demand of new emerging workforce (Shoushtari, 1997), and the decline of industries and/or their relocation to cut costs (Greve, 1997; Mitter, 1994; Sieh, 1997; Tong, 1997). Sieh gave a different reason for the rise of the informal sector in the north. It is to escape the repetitive work and progressive income tax burden and to make better use of professional qualifications (Sieh, 1997). Despite its importance and prominence, the informal sector and its workers continue to be ignored and marginalised. There is a potential that with appropriate policy support, the informal sector could become an avenue to address the growing unemployment and pervasive poverty (Greve, 1997; Kim, 1997; Ofreneo, 1997; Sieh, 1997).

Women form the bulk of the workforce in the informal sector. Three factors contribute to this situation. First, women of all ages and background are able to find work with fewer barriers than in the formal sector (Dasanayaka, 1997). Second, the flexible hours enable women to combine their productive (paid) and reproductive (childcare and domestic duties) work. Women are expected to cope with the demands of domestic responsibilities in addition to paid work (Dasanayaka, 1997; Greve, 1997). However, flexibility is a contested issue because it depends on from whose perspective it is being defined.[73] Women consider the informal sector flexible because it enables them to combine both paid and unpaid work, but from the market point of view, the informal sector is inflexible because it limits their work hours and hinders their productivity, and women lack the ability to adjust to the changing market demands (Makiasale, 1997). But in Hong Kong, it seems that the informal sector is flexible to meet the market demands (Tong, 1997). This relates back to the fluid notion of the informal sector. The third reason for the women's dominance in the informal sector is that they lack the skills and education to access better paying jobs (Ofreneo, 1997). Parents are usually reluctant to invest in the tertiary education of their daughters, which limits their choices, and they are unable to adapt to the changing economic environment (Greve, 1997; Ofreneo, 1997; Sieh, 1997). In addition, the socialisation of girls into gender-specific and culturally appropriate behaviour influences their choice of economic activities (Greve, 1997). All these lead to women being confined to a narrow band of activities at the lower end of the informal sector (Greve, 1997; Sieh, 1997).

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[73] Chhachhi (1999, p. 332) divided flexibility into three categories: (a) in relation to the organisational structure of the firm and its attempts to subcontract, relocate, and backward integrate; (b) in the pattern of production that refers to new pattern of work such as introduction of technology, automation, changes in labour process and job categories, job rotation, and training of workers for multiple jobs; and (c) in labour market flexibility, which relates to changes in labour laws, work status, and wages of workers.

The activities performed in the informal sector are heterogeneous; are scattered over a wide geographical location; require flexible or irregular hours; are usually low skilled, repetitive, and labour intensive; are unregulated; always tend towards feminisation; are sensitive to local and global market upheavals; provide irregular income; lack social security; are unprotected by any labour legislation; are vulnerable to exploitation, peripheral, part-time, and seasonal; provide minimal or no access to credit; combine housework and income-generating work; are self-employed; and lack ownership to assets (Chandola, 1995; Chen et al., 1999; Cisse, 1994; Greve, 1997; ILO, 1996b, 1996c; Kalpagam, 1994; Sieh, 1997; Mitter, 1994; Nguyen, 1999; Ofreneo, 1997; Rose, 1992; SEWA Annual Report, 1988; SEWA, 1989; UN, 1999; Vohra, 1997). Although most work in the informal sector is family based, what Sieh (1997) called "hobby or craft-based" (p. 54), the outsourcing of work by multinational companies (export or service oriented) such as electronics, clothing, and telemarketing into homes shows that informal work has found a more global niche (Mitter, 1994; Tate, 1994a, 1994b; Tong, 1997). This is because wages are kept to the minimum because there is an oversupply of labour (Tate, 1994a, 1994b). Tate called this group of workers "captive labour" (1994a, p. 61).

The informal sector is not an urban phenomenon. In the south it is found in the rural areas, where women are engaged in a range of activities from nonagricultural (artisan, cottage industries) to processing farm and food products and livestock rearing (Greve, 1997). The rural economy in Bangladesh is agriculture based, and it absorbs approximately 70% of the total labour force, the bulk of whom are women who are engaged in farm-related activities (Hoq & Begum, 1997). In Fiji subsistence crops—sugarcane, the export crop—grown by women account for a similar contribution to GDP (Makasiale, 1997). Fiji women grow these crops for their own consumption and sell the surplus, but agricultural statistics include neither the crops nor the revenue generated even though their gross margins are higher than the recognised commercial crops (Makasiale, 1997). In addition, women have boosted the growth of subsistence crops by increasing the acreage and thereby ensuring the availability of health food to urban and rural dwellers (Makasiale, 1997). Finally, the entry into the informal sector (whether rural or urban) is perceived as a last resort for women when they have exhausted all other avenues to earn income (Greve, 1997; Mitter, 1994). In Myanmar one of the reasons why women enter the informal sector is to pay off debts incurred by their families (Maung, 1997).

In part, the rise of the informal sector has been due to austerity measures (structural adjustments) imposed by international lending agencies to streamline and stimulate economic growth.[74] The outcome of these measures is economic crises that have resulted in the gradual disappearance of stable, salaried, secure, full-time jobs in the formal economy (Greve, 1997; ILO, 1996b). Women were pushed to participate in the informal sector under insecure and worsening economic conditions (ILO, 1996b; Mitter, 1994). However, adverse economic environment affects children and propels them into the role of workers.

Children assist their parents in a number of ways to ensure the continuity of the informal economy. In Myanmar, for example, children contribute directly to the informal sector by assisting their parents in their work (production of goods or rendering of services) or indirectly by assuming the household duties, thus freeing their mothers to engage in nonhousehold work (Maung, 1997). Maung found that in the latter case, children between the ages of five and nine were the main helpers. Children's involvement in the labour market leads to loss of opportunities and education, which perpetuates the cycle of poverty and marginalisation (UNICEF, 1997).

The degree and nature of informalisation differ in each country among informal workers and among similar groups (Mitter, 1994; Sieh, 1997). The different classifications reflect the different reality of informal workers around the world. But the multiple classification becomes a disadvantage when formulating policies and ensuring transferability to other jurisdiction. One consequence of the increase in informal work is the decline in the quality of working lives (Mitter, 1994). Inadequate workplace safety, health hazards, poor wages, and harassment (sexual and verbal) all contribute to the depletion of human resources, a vital condition to compete in the world economy (Mitter, 1994). Informal workers, many of whom are women, perform a variety of tasks to earn an income; they operate in the margins and yet contribute to the well-being of their families and country.

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[74] This relationship is not that simple. A government's good management of its finances is crucial to ensure that its economy is not vulnerable to any slight upheavals in the global market. Other factors include a stable political environment, social cohesion, and the way that governments and citizens manage the legacy of their past history. For further expansion of the role of history on work, especially colonialism, see Kalpagam (1994, p. 25).

Informal Economy: Home-Based Workers

Bhatt (1987) divided home-based workers into two categories. One group is provided with the raw materials by their 'employers,' who pay these women according to the amount produced (piece-rate);[75] the second group of women invest in the raw materials and then sell the finished products.[76] Because home-based workers do not have a clear employee-employer relationship and they perform their work in their homes instead of factories, their work is considered to be part of the informal economy (Bhatt, 1987; Chen et al., 1999; Dasanayaka, 1997; ILO, 1996a, 1996b, 1996c; Jhabvala, 1994; Ofreneo, 1997; Rose, 1992; Rowbotham & Mitter, 1994; SEWA Annual Reports, 1988-1998; Tate, 1994a, 1994b, 1994c). Home-based work is also known as *homework* and *outwork* (Tate, 1994a). In this dissertation I use the term *home-based* instead of homework because the latter could be confused with unpaid housework. Outwork does not convey either the precise meaning or the subtleties of home-based work. What is important to note is that home-based work assumes all the characteristics of the informal sector.

Rowbotham and Mitter (1994) used the terms *casualised work* and *casualisation*; SEWA, on the other hand, prefers to call these women *self-employed*. Although casual workers and self-employed refer to the same group of women, the different terminology illustrates the different philosophical perceptions of women's work. Rowbotham and Mitter noted that "casualised work" was used by European historians to describe seasonal and irregular work that persisted throughout the 19th and 20th centuries, and "sweated industry" was used to describe the emergence of the "low-paid, subcontracted and unorganised and unregulated work" (p. 3; Pennington & Westover, 1989; Tate, 1994a). SEWA's "self-employed" is a conscious political effort to remove the pejorative of the casual (unimportant and supplemental) valuing of women's home-based work and to increase their visibility and bring dignity to their work. However, Rowbotham and Mitter indicated that in the developed economies self-employment does not provide an accurate picture of casual labour or the predicament of low wages and exploitation. Sieh (1997) also cautioned the use of self-employment to describe women in the informal sector. This is because women who are enumerated as self-employed usually operate larger, permanent, and registered business premises (Sieh, 1997). According to Sieh, the use of self-employed to represent those involved in the informal sector would lead to an underestimation because it would exclude other home-based workers. At the same time, the definition of casual work by Rowbotham and Mitter does not take into account the changing nature of casualisation. For example, casual nurses in Alberta are unionised and are paid according to the salary scale agreed for all nurses in their contract. In addition, the contributions of casual nurses are accounted in the employment statistics, and there is a defined employer-employee relationship. Where Rowbotham and Mitter's definition of casual work converges with the experiences of casual nurses in Alberta is on the lack of social and financial benefits. Employers do not provide holiday, medical, maternity, sick pay, and other long-term benefits to casual nurses. In this sense, the casual nurses are at the lower end of the scale compared to full-time, permanent nurses.

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[75] Piece-rate payment is not confined to the home-based or informal sector. Nguyen (1999) noted that in Vietnam, women who work in the formal sector such as in the textile factories are paid piece-rate based on the output. Output depends on the worker's capacity to operate various machines. The more machines she operates and the faster she works, the greater the output and the higher the wages.

[76] Although the *Dais* do not fit into any of these categories, they are self-employed women who fall into the category of service providers.

The literature on home-based work in India and in other parts of the world indicated that there is little information about women's home-based productive work for cash income, and few accurate statistics exist on the number of women who are engaged in this type of work (Anderfuhren, 1994; Census of India, GOI, 2001;[77] Chandola, 1995; Chen et al., 1999;

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[77] This has changed. According to Ms. Namrata Bali (personal communications, April 1999), SEWA Academy Coordinator, SEWA's groundbreaking work in promoting self-employed women's contributions has led to the revision and inclusion of women's work for the upcoming 2001 Census. The 2001 Census shows that between 1991 and 2001, the number of workers increased from 314 million (m) to 399 m (27.2%), whereas the population increased from 837m to 1015m (21.2%) during the corresponding period. The net addition of male population between 1991 and 2001 is 91m (20.8%), but the net addition of male workers was only 49m (21.8%). On the other hand, there was an increase of 40.6% in female workers, although the female population increased by 21.7% between 1991 and 2001. Among women workers, out of 36m total workers, 28m (77%) were marginal workers. The enumerators noted that

Dasanayaka, 1997; Kalpagam, 1994; Kim, 1997; Makasiale, 1997; Mehra & Gammage, 1999; Mitter, 1994; Mitter & Rowbotham, 1994; Singh & Kelles-Viitanen, 1987; Tate, 1994a; Tong, 1997; Walker, 1989). In India, due to the paucity of data, a Commission on Self-Employed Women and Women in the Informal Sector was set up in 1986 by the late Prime Minister Rajiv Gandhi to ascertain the contributions and the work of these women. Ela Bhatt, one of the founders of SEWA, was appointed the chair of this commission in 1987 (SEWA, 1989). The findings of the commission "proved once and for all that self-employed women are a large, important and essential segment of our economy" (Jhabvala cited in SEWA, 1989, p. iii). Jhabvala recounted SEWA's struggles when it tried to make the contributions and the needs of self-employed women visible to policymakers:

> We were told they did not exist: "Women were housewives, they did not work; self-employed workers were only a small section of the economy and mainly independent businessmen; women worked part-time in their 'leisure' time and could not be counted as workers at all; the working class was in the factories, the self-employed were not workers at all." In other words, we [SEWA] found that whenever we began to raise the issues of self-employed women, we had first to answer questions about their very existence. We began to discover the anomalous situation that 89% of [the] work force was in fact invisible; it did not count as part of the labour movement; its contributions to the gross national product was [sic] rarely accounted for, and the women workers were not even counted by the census. (SEWA, 1989, p. iii)

Shramshakti provided the most authoritative data about self-employed women in the informal sector of India (Kalpagam, 1994). Over four fifths of self-employed women earn less than Rs. 500 per month, and about one tenth of women earn Rs. 100; and over 60% of women are engaged as self-employed workers (SEWA, 1989). In the findings, Shramshakti discussed the impact of macro-policies (from technological changes to urbanisation) and identified "the vulnerabilities and survival problems of women workers across a wide range of occupations and activities" (Kalpagam, 1994, p. 38). The commission recommended an integrated and holistic

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> significantly higher rate of growth of female workers as compared to the growth of female population clearly brings out better capture of women's work. . . . The significantly large increase in the number of female cultivators and agricultural labourers during 1991 and 2001 is largely perhaps due to improved coverage of female workers. (eCensus, 2001, pp. 1-2)

approach when planning strategies to address women's employment and other basic needs (SEWA, 1989).[78]

The hard work of SEWA and other NGOs such as HomeNet finally paid off in 1996. On June 4, 1996, the International Labour Organization (ILO) convened for its Eighty-Third Session and ratified a treaty that laid out clear guidelines in its Article (1)[79] to distinguish home-based workers from other categories of workers. In addition, the ILO meeting was a landmark event because it produced a document with provisions that governed the rights of home-based workers (who are mostly women) in an international setting and recognised their contributions to the global economy. Home-based workers in India share certain characteristics that are found in varying degrees in many parts of the world. Many of them are low paid, work long and erratic hours, and contribute substantially to their family income, but "they are not perceived as workers either by the women themselves or the data collecting agencies and the government, as all of them do not recognise the multidimensional functions of women which include their productive and reproductive labour" (SEWA, 1989, p. 1). Other authors have made similar observations (Bangasser, 1994; Baud, 1987; Bhatt, 1987; Bhatty, 1987; Chandola, 1995; Chen et al., 1999; Jhabvala, 1994; Kalpagam, 1994; Rao & Husain, 1987; Rose, 1992).

Home-based workers perform a variety of activities such as domestic, rolling *bidi* (indigenous cigarette), *chikan* (eye-let embroidery), crocheting lace, *agarbatti* (incense), cutting betel nuts, stitching paper and gunny bags, ironing clothes, brass making, manual labour, tailoring, pottery making, block printing, and tie and dye (SEWA, 1989). These workers are prone to various health hazards. They suffer from respiratory problems and reproductive disorders and develop cancers, failing eyesight, lower back pain, fatigue, stomach ulcers, and dizziness (SEWA, 1989).

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[78] This includes (a) providing access to fuel, fodder, and water to meet their basic requirements; (b) strengthening their existing employment by providing appropriate support for skills training, credit, and marketing; (c) protecting their employment in sectors where there is a decline due to technological changes; (d) creating new employment opportunities for women based on local markets for mass consumption; (e) protecting women from casualisation and contractualisation which leads to their exploitation; (f) providing supportive services to women such as housing, childcare facilities, and sewage; and (g) properly and effectively implementing industrial and labour laws (SEWA, 1989, p. 120).

[79] Article 1: For the purposes of this Convention (a) the term *home work* means work carried out by a person, to be referred to as a home worker, (i) in his or her home or in other premises of his or her own choice, other than the workplace of the employer; (ii) for remuneration; (iii) which results in a product or service as specified by the employer, irrespective of who provides the equipment, materials, or other inputs used, unless this person has the degree of autonomy and of economic independence necessary to be considered an independent worker under national laws, regulations, or court decisions; (b) persons with employee status do not become homeworkers within the meaning of this Convention simply by occasionally performing their work as employees at home, rather than in their usual workplaces; (c) the term *employer* means a person, natural or legal, who, either directly or through an intermediary, whether or not intermediaries are provided for in national legislation, gives out home work in pursuance of his or her business activity. The ILO Convention document can be found on the HomeNet Home Page at http://www.homenetww.org.uk/conv.html (October 2001).

Home-based work provides an avenue for women to improve their economic status, especially when movement outside the home is restricted (Baud, 1987). For example, Muslim women do tailoring and *chindi* stitching (quilting) at home, and the products either are sold by their male family members or are piece-rated (Baud, 1987). For others, it is a way of earning an income and meeting their domestic responsibilities. A study by Noponen (1987) in Madras showed that young, more educated women with young children opted for home-based work because it provided proximity to their children and they were able to combine it with housework and childcare.

In summary, despite the precarious nature of home-based work, it is the only avenue for women who are unable to find any other route to earn income. Women are the first to be retrenched due to technological changes or restructuring; however, they are not presented with viable alternatives that could provide them with equal level of income or work security. Home-based work does not obviate the double burden that women workers experience. In fact, it adds to their monotony and burden and has multiple health effects. Home-based workers also do not have social security that would cushion them during difficult times. Although in many instances home-based services and trades cater to the local population, they are still vulnerable to the global economic upheavals.

Home-based work is the only viable and accessible alternative for many women who are unable to secure better paying or stable jobs. In the south home-based work provides women with an avenue to avert the grinding poverty and meet their basic needs. However, the focus on the economics of home-based work should not detract from the fact that it is feminised in nature. Women earn low wages and are stuck in low-skilled work, which perpetuates their marginal position. Another reason is the sociocultural factors that affect their access to education (training and skills) and credit. Based on the research of textile and electronic industries that explores the impact of technology and training on women workers (Chhachhi, 1999; Nanda, 2000; Nguyen, 1999), it was found that training is critical to prevent women from being pushed out of the formal sector.

The Training of Indigenous Midwives

Previous research findings show that the indigenous midwives around the world work within a larger socioeconomic and political system and are subject to various health policies. The policy that has direct effect on their work is training. But the literature did not indicate whether the learning needs of these midwives are taken into account (with the exception of Jordan (1978/1993) or whether they are consulted about the contents of the materials that are used to 'train' them. What is clear, however, is that these interventions are related to the needs of the formal health care system (GOI, 1982; SIHFW, 1999; Swaminathan et al., 1986).

The various attempts by governments (India and other parts of the world) to train their indigenous midwives provide a fertile ground for the discussion of power, knowledge, and work. The global and correct language of the UN's health documents such as the HFA and the RCH masks the domination of biomedical knowledge over indigenous learning. The language also implies that the indigenous practitioners have a role to play in the national health system on an equal level. In reality, they do not. Indigenous midwives have been a target for 'integration' by their respective governments, in one way by teaching them to adopt the practices of the biomedical establishment. In the context of primary health care, they were (and continue to be) perceived as key players in providing accessible and affordable maternal and child health. The Alma-Ata Declaration provided the impetus to train these women, although their training in some countries began much earlier than the Declaration. The outcome of this training has been mixed in part because the training focussed on correcting harmful practices and teaching the midwives biomedical work in isolation, without considering the cultural and social contexts of the women. However, Judith Justice's (1984) work with the Auxilliary Nurse Midwife (ANM) in Nepal shows that even if relevant sociocultural information is available, it does not guarantee that culturally appropriate health programmes will be constructed, especially if it is to serve the multiple interests of various stakeholders.

The other reason is that merely training the indigenous midwives without establishing adequate infrastructures to support them means that neither they nor the women for whom they care have any recourse for assistance. Rural areas of many countries lack good and accessible roads, appropriate health care facilities, and qualified health workers. In addition, the contents of the midwives' basic delivery kit or individual delivery kits that were provided to assist them to conduct safe deliveries were not replenished or made available after the initial distribution.[80] Hence the midwives in Ethiopia reverted back to their pretraining practices, including using the indigenous materials, when the supplies were not replenished (Alemayehu, 1997). Jordan (1989) too noted the same phenomenon among the Yucatan midwives. Although their actions may appear to be regressive, these midwives were actually practicing the ideals of the HFA; namely; using appropriate and accessible technology to conduct their work.

The aim of the training, according to WHO (1992), was as follows:

> Because of the current shortage of professional midwives and institutional facilities to provide prenatal care and clean, safe deliveries as well as a variety of primary health care functions . . . to bridge the gap until all women and children have access to acceptable, professional, modern health care services. Trained TBAs may contribute to safe motherhood, family planning, child survival, and health for all. . . . They should be encouraged until more qualified personnel have been trained, are in position in a modern health service, and are accepted by the community. Conditions vary so greatly throughout the world that decisions to initiate, invigorate or discontinue a TBA programme should be made only after a thorough review of the complex array of issues, resources, and sociocultural factors including the **wishes** of families and **the TBAs themselves**. (pp. 2-3; emphasis mine)

Various authors pointed out that those who are selected for the training are usually older married women or widowed, had borne children, are residents in their respective villages, have good relations with community members, and are currently working as indigenous midwives (Bajpai, 1996; Chowdhury, 1998; Jordan, 1989, 1993; Nessa, 1995; Stephens, 1992; WHO, 1992). WHO proposed the following criteria: age, literacy, motivation, respect in the community, and caseload. There is a consensus that selection criteria should be determined through community consultations (Alto et al., 1991; Foster, 1987; Justice, 1984; Nessa, 1995; Pigg, 1995, 1997; Stone, 1986, 1992; WHO, 1978, 1992). Selection through consensus is based on the belief that community participation is egalitarian and inclusive, the inference being that everyone will be able to participate equally. But community participation has been used to introduce new ideas, to oppress, to assign additional powers to the elite, or to create a new elite (Pigg, 1995, 1997; Stone, 1986, 1992). Smith (1998) noted that a few *Dai*s were dissuaded from attending the training because it was feared that they would pose a threat to the local nurses. In the example of the Angal Heneng, community consultations occurred between the men and the midwife trainer (Alto et al., 1991). Those who were chosen for the training were related to the chiefs, health workers, or the village pastors. These women and their families used their Christian beliefs to legitimise their involvement in the defiling work. The authors therefore justified their interventions and the introduction of new cultural roles on the grounds that there has been a decrease in neonatal and infant mortality amongst the Angal Heneng. They concluded that,

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[80] This problem was highlighted during the meeting of the NGOs in Ahmedabad. Tribhuvandas Foundation, which manufactures and supplies the *Dai* Disposal Delivery Kit (DDK) in Gujarat, revealed that regular supplies of DDK are often late because the quota from the government is often late.

> despite the customary prohibitions, it has been possible to train village midwives to provide obstetrical services in a remote part of Papua New Guinea where there was previously no cultural role of traditional birth attendants, . . . and the village midwife has now filled this void. The VMWs' [indigenous midwives'] geographic accessibility in the village and their sharing of the same cultural orientation as their clients have permitted easy integration into the birth practices of the women. (Alto et al., 1991, pp. 616-617)

Thus Stone (1986) observed that both the primary health care and the community participation are ways of "address[ing] the concerns and trends of an external world, rather than the world of the villager" (p. 297). The Angal Heneng example illustrates this point well. The question that arises is whether genuine community participation actually occurs or whether the term is simply political rhetoric. Both Pigg (1995, 1997) and Stone (1986, 1992) noted that so far it has often been the latter. Stone (1986) remarked that the ideals of primary health care encourage the community *to define their own health needs,* although in most instances the implementers of the primary health care have defined beforehand the parameters pertaining to the participants, their health needs, and the range of solutions to address them (p. 299). Using the strongest language possible, Stone suggested that "PHC [HFA] give up some of its pretensions of 'community participation' and concentrate on tailoring its activities to more fully accord with community interests within a broader concept of development" (p. 299). The training of indigenous midwives is an example of this top-down decision making under the guise of community participation, which Pigg (1995, 1997) explored under the rubric of development.

According to Pigg (1995, 1997), the notion of the traditional is essential to development discourse because it presents a common denominator of disparate situations, which development can bring under control. Contextualising indigenous midwives' training within development discourse leads to the standardisation of the multiple interpretations of indigenous healing as the monolithic traditional. Without this uniformity that is provided by the notion of the traditional, Pigg noted that development's entry into the space and its authoritative management of indigenous healing would be restricted. Targeting the 'harmful' and 'harmless' practices of the indigenous midwives enables development workers to "locate precise 'points of intervention'" (Pigg, 1995, p. 56) enforcing biomedicine's authority and subordinating the accepted local beliefs of health. The training operates on the premise that social and cultural aspects of birth can be separated from the biological, thereby medicalising births and omitting local knowledge. In addition, incorrect interpretations of the local practices have further reinforced development's stereotypical images that many indigenous practices are harmful and therefore have to be corrected (Pigg, 1995, 1997). These images provide the points of intervention for training and the fragmentation of local indigenous knowledge of the midwives (Jordan, 1989; Pigg, 1995, 1997; Stone, 1986, 1992). The training has widened the chasm between the two systems of knowledge and led to the disempowerment of the indigenous midwives.

Conclusion

So far the work of the midwives has been discussed in relation to the needs of their clients and the health care system. However, what is unknown is how midwives' work affects their own health. One way that this research tries to answer this is to explore work through various perceptions. Because work is a social process that shapes and is shaped by workers' beliefs and values, understanding the multiple perceptions of individuals and the midwives could increase our understanding about health and work. This link between perceptions and work and health has not been addressed in the literature.

The literature was also silent on the effect of training on work. Although training has been discussed in the context of correcting midwives' knowledge and practices, what has been omitted is the creation of hierarchy within the ranks of indigenous midwives. The question that arises is whether training has created two cadres of midwives. Has training led to better opportunities for midwives? Have their incomes increased and perceptions of their work changed in society? These questions have not been fully explored in the past because the focus had been to decrease infant and maternal mortality rates.

Linked to training is the issue of skills, types and levels of skills and their influence on the nature of work. The literature on the changing nature of the electronics and the garment industries showed that skills are not merely a set of actions to achieve work output, but they are also politically and socially defined and are subject to change. This concept has not been fully examined in the case of the indigenous midwives to bring about a deeper understanding of their work. As informal workers, their contributions and skills are devalued because these are perceived as static instead of evolving.

CHAPTER 6

RESEARCH METHODS: FIELDWORK AND DATA ANALYSIS

Introduction

In this chapter I present the strategies that I utilised to access the multiple perceptions about *Dai*s' work. It includes the initial preparation at the University of Alberta, the events in the field and the strategies used to access data and data analysis post-fieldwork. The rationale for each of the strategies adopted and their limitations and strengths are also discussed. Ethical issues arising during fieldwork and how they were addressed are also presented.

Fieldwork: Beginnings on Campus

My fieldwork began on campus at the University of Alberta, Canada, continued in Gujarat, and was completed back on campus. I chose to conduct my research on women's work using a qualitative approach. My decision to focus my research on women's work stemmed from my own personal experience of being a nurse, a profession that is predominantly female, and I chose a qualitative approach because I was interested in the rich, lived experiences of the *Dai*s and those around them.

The initial process of fieldwork included developing the research question, establishing ties with SEWA, and preparing proposals for submissions to the University of Alberta's Medical-Sciences committee, my Ph.D. supervisory committee, the ethics committee, and the various funding agencies. The structure of my proposals varied with the requirements of the agencies and the committees. Proposal revisions were time consuming and laborious, but they provided me with opportunities to develop my ideas and focus my research. Marshall and Rossman (1995) stated it well when they observed that

> researchers who would conduct qualitative research face at least three challenges: (1) to develop a conceptual framework for the study that is thorough, concise and elegant; (2) to plan a design that is systematic and manageable and yet flexible; and (3) to integrate these into a coherent document that convinces the proposal reader—a funding agency or a dissertation committee—that the study should be done, can be done, and will be done. (p. 5)

These authors, however, noted that the high expectations of producing well-defined proposals from novice researchers is paradoxical because, on the one hand, the aim of the proposal is to train them to become competent in articulating their ideas; however, there is an unspoken expectation that these researchers should be able to develop their conceptual framework in crystal-clear terms, similar to experienced researchers. In addition, researchers are expected to demonstrate flexibility and adapt their designs as the study evolves (Hammersley & Atkinson, 1995; Marshall & Rossman, 1995). The need for flexibility was further reinforced by Berg (1998) and Shi (1997). Both asserted that researchers must be perceptive and open to alternative methods because "the pursuit of knowledge will suffer if researchers only recognize the paradigms of their own disciplines. The tendency to promote one method at the expense of others can prevent researchers from seeing complementarity of various methods" (Shi, 1997, p. 37).

These were some of the factors that I had to consider each time I revised my proposal. I had to consider my audience and tailor my proposal according to their knowledge and expertise. As a novice researcher, the process taught me to balance between the format as stipulated by the agency or the committee and my research goal and objectives. One example was learning to present my qualitative research in a quantitative format to the Medical Sciences Committee. Indeed, the ability to do just that led me to believe that flexibility is an important skill to develop and nurture. Unknown to me at the time, this initial event became the precursor to other times when I needed to exercise flexibility in both presenting my research and changing my approach in the field.

Qualitative Methods: Convincing the 'Other'

As noted previously, learning to present my research in different formats to funding agencies and to committees was one challenge. The other challenge, related to the first, was to convince those who were adjudicating my research proposal that the approach that I was using to conduct my research was valid and a work of science. As a student in the Department of Public Health Sciences in the Faculty of Medicine, this was the challenge that I encountered during the preparation for my fieldwork. I had to convince members of the Medical Sciences Committee (most of whom were unfamiliar with qualitative research methods) "that the study should be done, can be done, and will be done" (Marshall & Rossman, 1995, p. 5) using a combination of diverse qualitative methods such as interviews (individual and focus groups) and participant observation. Because I was presenting a different paradigm to these adjudicators, they were unsure whether this was 'scientific work.' Berg (1998) observed:

> Although various technologies may be used by different researchers, it turns out that everyone is doing science, provided that *science* is defined as a specific and systematic way of discovering and understanding how social realities arise, operate, and impact on individuals and organizations of individuals. (p. 11)

Thus my research is a work of science. My proposal stated clearly the goal and objectives of my study and listed systematically the various strategies that I intended to use to conduct my fieldwork in Gujarat.

In addition to presenting a strong argument regarding the benefits of multiple research strategies, members of the Medical Sciences Committee had to be satisfied that my research work would be enhanced if other participants—that is, individuals with whom *Dais* interact—were involved. Because qualitative research seeks answers to questions by investigating various social settings and the individuals who occupy these settings (Berg, 1998; Bernard, 1995; Marshall & Rossman, 1995; Morse & Field, 1995; Shi, 1997), the involvement of various participants and methods would provide multiple perceptions of *Dais*' work in rural and urban Gujarat, increase the validity of the study, and allow triangulation of data. My decision to use multiple strategies to access data and involve various participants was further supported by Berg's observations that "qualitative researchers, then, are most interested in how humans arrange themselves and their settings and how inhabitants of these settings make sense of their surroundings through symbols, rituals, social structures, social roles" (p. 7).

Both the Medical Sciences and the dissertation committees had to be persuaded that my personal interest would not affect the rigour of my qualitative study. Both quantitative and qualitative strategies depend on the researcher-as-the-instrument. There is a perception that instruments used in quantitative methods are independent of human bias and therefore are objective and valid. In qualitative work, the researcher is the instrument throughout the research process, and there is a perception that he/she may insert his/her bias and subjectivity. I chose the ethnographic method because the goal of this research was to understand the multiple perceptions of *Dais*' work and how these affect their health. The ethnographic method would provide me with data from different points of view, which I could use to obtain a varied description of the *Dais*' work. This is why I planned to conduct in-depth interviews and participant observation and to maintain fieldnotes.

Fieldwork in Gujarat: Testing the Ground

> Fieldwork must certainly rank as one of the most disagreeable activities that humanity has fashioned for itself. It is usually inconvenient, to say the least, sometimes physically uncomfortable, frequently embarrassing, and, to a degree, always tense. . . . Field researchers have in common the tendency to immerse themselves for the sake of science in situations that all but a tiny minority of humankind goes to great lengths to avoid. (Shaffir & Stebbins, 1991, p. 1)

Ethnographic fieldwork involves immersing oneself in the culture of the participants for a period of time, which allows the researcher to understand the phenomenon within its sociocultural, political, and economic contexts (Morse & Field, 1995; Shaffir & Stebbins, 1991). Most fieldwork research is exploratory. Researchers enter the field with certain orientations and approaches towards their work, but at the same time maintain flexibility and openness to alternative understanding and methods (Bernard, 1995; Marshall & Rossman, 1995; Morse & Field, 1995; Shaffir & Stebbins, 1991). Furthermore, exploratory studies are conducted when there is little known about the phenomenon. Data-collection techniques include participant observation, semi-structured interviews, document analysis, and other noninteractive modes.

My entry into the field began with my initial contact with SEWA. I corresponded with SEWA over a period of two years (1997-99) before leaving for India. Mirai Chatterjee, the secretary-general of SEWA at the time, supported my application because my research topic coincided with SEWA's goal to understand *Dais*' work more deeply. She indicated that my research would assist SEWA in its goal of increasing the *Dais*' visibility by presenting the extent of their contributions to the health care system. In addition, my research fits well with SEWA's continued work in capacity building among the *Dais*. Fieldwork was necessary for my data collection because the objective of my research was to compare two groups of *Dais* in Gujarat: SEWA and non-SEWA. Bernard (1995) referred to the main subject of study as the *basic unit*. In addition, I planned to interview their clients, family members, village leaders, health care workers, and government officials using focus groups and individual interviews. However, my original data collection and intent changed once I was in the field, for reasons that I explain below.

Gaining Access: Gatekeepers and Letters of Introduction

Gatekeepers and Key Informants

In any fieldwork there are individuals who control the access to a research setting. They are the gatekeepers and key informants, individuals in the organisation who have the power to grant or to withhold access to people or situations for purposes of research (Berg, 1998; Bernard, 1995; Burgess, 1991; Marshall & Rossman, 1995; Shaffir & Stebbins, 1991; Punch, 1986; Thomas, 1993). Shaffir and Stebbins observed:

> The chances of getting permission to undertake the research are increased when the researcher's interests appear to coincide with those of the subjects . . . and to a degree on the study's specific focus. Gatekeepers of formal organizations may believe that the research will report favorably on an issue they wish to publicize. (pp. 26-29)

My research was no different. There were various individuals who exerted direct or indirect influence on my research. My initial letter of inquiry to SEWA stated my desire to conduct my research with the organisation. In the letter I asked if there were any issues that SEWA would like to have researched. SEWA requested a copy of my curriculum vitae, and in the accompanying letter I indicated that I had written a research paper about the *Dai*s. Mirai Chatterjee of SEWA then invited me to conduct my research on the *Dai*s in SEWA because the organisation was working actively with the *Dai*s (Appendix A). The Government of India (GOI) supported my research because it fit with the overall policies of *Reproductive and Child Health* (RCH; Appendix B). My research was approved because it met the needs of two key stakeholders. Mirai's support during the search for funding was crucial. She wrote letters of support to the various organisations to which I was applying for research funding. Her support legitimised my research because it indicated to the funding agencies that my entry into the organisation was valid and had the approval of the leaders.[81]

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[81] SEWA's worldwide reputation for embarking on innovative work with women who are perceived to be "lost causes" (poor, self-employed women) is well established. This helped me tremendously because I did not have to explain what SEWA was all about. Simply writing *SEWA* on proposals was adequate.

Shaffir and Stebbins (1991) noted that it is not unusual for a researcher to negotiate with multiple gatekeepers to secure access to all facets of the setting. Lofland and Lofland (1984) suggested that entry into the field can be facilitated if the researcher provides a credible, plausible, and focussed account justifying his or her research interests, has some connections to the person in the setting, and is perceived by those to be researched as a personable and decent human being.

Aside from gatekeepers, access to the field is further shaped by the social and political contexts within the study as evaluated by others, as well as by the nature of the relationships established between the researcher and the participants, including key informants, that is, individuals who have intimate knowledge about particular issues (Burgess, 1991; Marshall & Rossman, 1995; Punch, 1986; Shaffir & Stebbins, 1991; Thomas, 1993). Access to the settings and the participants is contingent upon relationships with gatekeepers, and key informants, as well as roles adopted in the field that either advance or impede the direction of the research and quality of the data. (Burgess, 1991).

In addition, access is shaped by the cultural and ascriptive differences between the field researcher and the participants, such as gender (Gurney, 1991; Lal, 1996; Kabeer, 1994; Luitel, 1996; Patai & Gluck, 1991; Stanley & Wise, 1983; Warren, 1988; Wolf, 1996); ethnicity (Lal, 1996; Luitel, 1996); religion; education (Kabeer, 1994; Lal, 1996; Luitel, 1996; Thomas, 1993); and socioeconomic status (Lal, 1996; Luitel, 1996). The capacity to transcend these differences and the roles that the researcher assumes influence the collection of data (Shaffir & Stebbins, 1991).

Multiple Gatekeepers, Multiple Points of Entry

Shaffir and Stebbins (1991) stated that permission is granted by those with authority and power, and my fieldwork experience corroborated this. While I was in India, my entry into SEWA was facilitated by Mirai, Mittal[82] and SEWA's health supervisors. Mirai introduced me as someone from Canada, but of South Asian descent. She mentioned that my parents were originally from Uttar Pradesh (UP), from Bharat.[83] In this way, she emphasised my commonality with the women; I was an insider and not a 'foreigner' or an outsider. The health co-ordinator, Mittal, and supervisors informed SEWA members at various levels of my presence and the purpose of my visits in the field. In addition, I attended various SEWA health meetings with them (and Mirai), which enabled me to meet with other SEWA health members and teams from different parts of Gujarat. Through these various contacts I was able to network and obtain informal referrals to health officials at the state level. For example, while attending a state level workshop on RCH, I met a gynaecologist related to the Minister of Health, and she facilitated my meeting with him.

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[82] Mittal Shah joined SEWA as a pharmacist and worked at one of SEWA's medical shops for eight years. For the last two years she has been working as the coordinator. I use first names of SEWA leaders and women to denote familiarity. I do so throughout the dissertation in the text unless I am citing published works by these individuals, at which time I use their surnames.

I took a similar approach (as with SEWA) to access public health care personnel. At the district level I introduced myself to the Chief District Health Officer (CDHO) of Mehsana and Ahmedabad City, using the letters of introduction. At each Primary Health Centre (PHC) I would approach and introduce myself to the Medical Officer (MO) and his/her staff, such as the female/male health supervisors (F/MHS), female/male health workers (F/MHW), and other support workers. In many instances it was prudent for me to maintain good relations with the F/MHWs because they (like SEWA's CHWs) had intimate knowledge about the villagers under their care. Despite maintaining good relationships, I encountered one gatekeeper, an FHS, who advised one of the *Dai*s *"not to answer the questions in detail, just superficially"* (NSMeh29).[84]

As my fieldwork progressed, however, I noted that those who initially seemed to lack power were potential gatekeepers. My research assistants fell into this category. They were SEWA's health researchers. Their education ranged from Grade 10 to Baccalaureate (Arts). The SEWA Health Co-operative recruited women from various backgrounds to conduct research work (there are 10 SEWA researchers). These women were given research training by SEWA. In addition to research, these women assist the health supervisors and health care workers to conduct various mobile health clinics. My research assistants were familiar with the survey techniques but not with the probing or open-ended questions. The rationale for my selecting them was that they were unmarried, and therefore they could accompany me to the villages and stay overnight at these different places without worrying about their obligations to their husbands and members of the joint family. They also facilitated dialogue between the participants and me. The research assistants used their knowledge of SEWA's community work to locate individuals and organisational information for me. Furthermore, SEWA women were at ease with them and their presence ensured that I was able to access SEWA's past research data on health and be informed of the current health work. In the latter part of my fieldwork, the research assistants became my key informants, teaching me the various subtle meanings of cultural and social aspects of childbirth and conception.

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[83] *India* is the name given by the former British colonials. However, India's ancient name is *Bharat*. This is a name that many Indians still use, the other being *Hindustan*.

[84] I am using codes to maintain participants' confidentiality.

Another unlikely group of gatekeepers was SEWA's community health workers (CHWs) in the villages and the urban slums. These women live in the communities in which they carry out SEWA's health work and other initiatives. SEWA selects women who are trusted members of their communities, exhibit leadership potential, are hardworking, possess intimate knowledge of their environment, and understand the social and economic issues that affect their communities. Many of these women are poor and socially marginalised. By selecting these groups of women to carry out SEWA's work, SEWA attempts to empower them and reach out to other marginalised and poor women. The CHWs, by virtue of who they are and their knowledge, facilitated my fieldwork by establishing trust between the interviewees and myself.

Apart from the obvious gatekeepers, there were other individuals (who were not visible at the outset) who had power to either obstruct or facilitate my fieldwork. One such group of individuals was those who had immigrated to the US but still maintained links with their home villages, and who spoke a smattering of English. Whenever I was in the village, these individuals, out of curiosity, would either come to meet with me or I would be taken to meet with them. They (all were males) would ask me in English the purpose of my research and the reason for conducting interviews/surveys in their respective villages. The exchange in English added prestige at different levels: first, to my research because they understood it, and to me, because I spoke with men of authority; second, to these individuals because they knew the language that allowed them to communicate with someone from a Northern nation; and third, to the villagers because they had someone in their midst who could communicate with the outside world in a foreign language of international importance. I tried to ensure that I had many and varied linkages by networking with everyone: from state officials in Gujarat, UN officials in New Delhi, and academics, to members at the grassroots and various NGOs (although this was not a guarantee, as

I found in my field research). Individuals were the main gatekeepers, and other forms of entry included letters of introduction.

Letters of Introduction from the Government of India (GOI), the Shastri Indo-Canadian Institute (SICI), and SEWA

These letters of introduction facilitated my entry at various levels in the field. For example, I used GOI's and SICI's letters (Appendices B and C, respectively) when I interviewed Gujarat health officials and policy makers, and individuals at the various UN offices in New Delhi. These letters gave legitimacy to my research. SEWA's letter (Appendix D), however, was effective in accessing members at the grassroots level such as local NGOs and resources such as libraries and documents. I learned in the field when and which letters to use to gain access to individuals and data. Whereas in some instances these letters of introduction served as important 'passports,' in other instances they created barriers and resistance. Learning from these experiences, I became adept at deciding which to use and when. I also found that entry into a situation or resources became available or opened when I mentioned being a PhD student from a university in Canada. There was therefore no single strategy to gain or negotiate entry into the field. Health officials at the district and state levels, academics, and UN officials were comfortable speaking with me when they saw the formal letters from the GOI and SICI. The offices of the GOI and SICI are based in New Delhi. SEWA leaders, however, did not require the letters because Mirai was my link to SEWA. Because the letters were written in English, they were not applicable to the SEWA *Dai*s and non-SEWA *Dai*s or to other women. To them I explained who I was and what I was doing, either through the health officials (non-SEWA *Dais*) or through my research assistants (SEWA women and *Dais*) since I did not speak Gujarati. Each entry was situationally specific.

Negotiating With SEWA

During my initial meetings with Mirai, she suggested that one of the ways to begin my research would be to interview various SEWA leaders (some of whom were in administrative positions) and other key individuals to give me a sense of SEWA. In addition, she noted that this would be one way to introduce myself to members so that they would know who I was and what my research was about. The information from the personal interviews was valuable because it enabled me to contextualise my research on *Dais*' work, and I gained a greater understanding about SEWA's approach and strategies for regular work and income and capacity building. I also attended a few of the health co-operative's meetings with Mirai so that I would be introduced to health workers (some of whom were *Dais*), supervisors, and researchers. Being introduced by Mirai was advantageous for me because, as a leader and a SEWA member, she was trusted by women and she was known. Mirai was one of the gatekeepers and, at the same time, my SEWA sponsor.

Once I had done the various interviews,[85] as Mirai had suggested, I proceeded with my original research plan. During one of our informal meetings, I presented to Mirai my tentative research plan. She supported my (original) plan but thought that doing a *Dai* survey would be useful to the SEWA Health Co-operative and to my research because it would provide a profile of the women in whom I was interested. Furthermore, SEWA did not have the data. Both Mirai and Mittal felt that the survey of the *Dais* in Mehsana district would provide the data that SEWA needed for future work. In addition, the *Dai* co-operative in this district was in the process of being formally registered, and the profile would enable SEWA to present the information to the registrar. The survey questionnaire would collect data about *Dais*' families, work, training and apprenticeship history, and socioeconomic status.

Building Trust: Volunteering

Volunteering was another strategy that facilitated my entry into SEWA and established trust with SEWA members. In my initial letter to Mirai, I had indicated that I would be willing to do some volunteer work for SEWA. While in the field, I edited SEWA's Annual Report (1998) and analysed SEWA's Baseline Health survey results from three districts and Ahmedabad City. I wrote brief reports on each of them and conducted a comparative data analysis. I also contributed photographs to the SEWA Health Co-operative. I used various strategies to cultivate and maintain good relationships with individuals[86] at various levels of the SEWA structure. By contributing to SEWA in a small way and following through the commitment I had made, I proved that I could be trusted and was willing to contribute. I demonstrated that I was not present simply to conduct my own research. My willingness to interact with SEWA women at all levels indicated that I was not a proud foreigner.[87]

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[85] This took over a month because women were difficult to access because of the demands on their time.

[86] This includes the various SEWA drivers and male staff. I was 'adopted' by two men as sister.

Data Collection

The goal of my research was to compare how SEWA and the Gujarat health care system accommodated the work of the *Dai*s and the implications of the different styles of accommodation for their health and the health of those around them.

Objectives of the Research

Three objectives were used to guide the data collection:

1. To understand the scope of *Dai*s' participation as decision makers in SEWA and Gujarat's health system. The data strategies to accomplish this objective included a survey and in-depth interviews with the *Dai*s and semi-structured interviews (individual or focus groups) with health care workers, *Dai*s' families, SEWA leaders and CHWs, and district and state health officials (please see Appendix E for description of sample and interview schedule). There were three sections in the survey form (Appendix F) that were developed to ascertain the *Dai*s' participation: (a) How do you want to change the rate of payment by the government? (b) What suggestions do you have for future training; that is, what changes do you want to see? (c) Do you have any other suggestions for the government or SEWA to assist you in your work? When I questioned the *Dai*s in-depth, I asked them whether any district or state officials (or in the case of SEWA *Dai*s, SEWA leaders) had consulted them regarding the amount of their payment, their ID card, or any health policies. I asked the state and district health officials if the *Dai*s' input had been sought in the current RCH framework, and I asked SEWA health leaders about the process in establishing the co-operatives. During my stay I was able to observe the discussions around setting up the *Dai* School by SEWA. Two meetings were held in which Mirai facilitated

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[87] Being 'proud' would have implied that I was unwilling to interact and get to know the women. This attitude would have isolated me. Many times the women at SEWA were amazed that I was willing to eat with them. My cooking was a source of amusement for them. They assisted my access to certain documents that would otherwise be impossible. For example, my good relationship with SEWA's telephone operator, Khalidabehn, helped me send faxes to my professors in Canada and make long-distance phone calls to Delhi and Singapore. Kamlabehn and Vasanthibehn assisted me with photocopying. Jayabehn, Mirai's secretary, helped me access various SEWA documents.

discussions with the *Dai*s and *agewans* (women leaders at the grassroots level) from various districts.

2. To examine the factors that influence the effectiveness of the work of *Dai*s inside and outside SEWA. In the survey forms the *Dai*s were asked about the availability of health personnel and the referral centres in the vicinity. This was to ascertain whether they knew where to send their clients if there were any problems during the delivery or if they deemed the pregnancy risky. Work narratives were elicited from the *Dai*s to provide information about their difficulties, experiences, and types of births they had attended, and from whom they sought assistance during difficult births. In addition, the *Dai*s provided information about their treatment by various biomedical personnel when they accompanied women. SEWA *Dai*s were asked their reasons for joining the *Dai* co-operatives and SEWA. In addition, the *Dai*s in both groups were asked for suggestions of changes they would like to see to improve their work environment. For example, *Dai*s were asked to imagine what they would say if a top health official asked for their opinions as to how to go about implementing this.[88]

3. To determine the nature of the *Dai*s' relationships with the biomedical establishment. The data for this were elicited from the *Dai*s using the survey. They were asked how biomedical practitioners treat them when they refer or accompany women to the hospitals/clinics and whether their relationships had changed since their training. This theme was followed up in the in-depth interviews. The *Dai*s were asked if they felt that they had contributed to the knowledge base of the FHW/FHS/SEWA trainers. I posed this question because I wanted to know how comfortable they were with the local health workers and the trainers and how confident they were with their knowledge and work. Another area of exploration was the issue of payment and replenishing the *Dai* Delivery Kit (DDK) stock. I asked the *Dai*s about the steps they took if they were not paid for the deliveries by the PHC staff or if they were unable to replenish their stock. Biomedical health workers provided additional information about their work and personal relationships with the *Dai*s using the semi-structured questions. Health officials who were in contact with the *Dai*s (retired or practising, such as trainers) were asked for their input on this. Aside from health

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[88] This question may appear simple, but the *Dai*s appeared to have difficulty answering questions that asked for their suggestions. One reason could be related to what Jordan (1993) had noted in the Yucatan midwives; namely, that they are attuned to a system that does things rather than talks about it. Another reason could be that many *Dai*s were uncertain whether anyone would listen to their suggestions. This response was found among both SEWA and non-SEWA *Dai*s and in urban and rural areas.

personnel, *Dais*' families provided further information about how people interact with the *Dai* and the effect of this relationship on them. SEWA health supervisors, health co-ordinator Mittal, and Mirai were asked for their own perspectives.

The Survey of the Dais

The survey provided a vast amount of data about the *Dais*. It included demographics, work narratives, history of training and apprenticeships, access to health facilities and transportation, payment, perception of work, history of deliveries, impact of training, and any other suggestions or comments that they wanted to add in addition to what was asked in the survey (Appendix F). The objectives of the survey were:

- to identify SEWA and non-SEWA *Dais*
- to understand *Dais*' beliefs and perceptions regarding women's health
- to identify *Dais*' skills and knowledge about reproductive health
- to identify *Dais*' workload in rural and urban areas
- to ascertain *Dais*' perceptions regarding the training programmes provided by various institutions/organisations
- to identify the constraints under which the *Dais* work.

These objectives were placed at the back of the survey form for two reasons. First, if someone wanted to peruse the forms prior to the interview for the rationale, they would be able to do so. Second, it provided a quick reference if there was a query regarding the survey during the interview.

Selection of the Dais for the Survey

Selection of the *Dais* was based on purposive sampling. I obtained a list of SEWA *Dais* in Ahmedabad City and Mehsana from the SEWA Health Co-operative. The SEWA health supervisor of Mehsana assisted me greatly in obtaining the names of Mehsana *Dais*. She informed the *Dais* about the purpose of my visit a week before my arrival, and introduced me to a female health supervisor (FHS) at one of the Primary Health Centres (PHC), from whom I obtained the names of some of the *Dais* under her PHC. The FHS further suggested that I meet with the chief district health officer (CDHO) in Mehsana. It was the CDHO's office that facilitated my meeting with non-SEWA *Dais* in two other *talukas* (subdistricts). The research assistants and I interviewed, in total, 95 SEWA and non-SEWA *Dais* from both urban and rural regions.

Pilot Testing the Survey Forms

The various steps in the formulation of the survey form are outlined in Appendix G. I met with all SEWA health supervisors during one of SEWA's weekly health meetings. Both Mirai and Mittal assisted me in explaining the purpose of my research to them. Before the actual surveys were conducted, I pilot-tested the original form with eight SEWA *Dai*s (four in Ahmedabad City [urban] and four in Ahmedabad District [rural]). The testing included ascertaining the clarity of the questions, the time it took to complete each survey, and how it was implemented (I was able to observe the research assistants at work). Post-testing changes included rewording some of the questions that *Dai*s and the research assistants found awkward, consolidating the questions that elicited similar answers, and deciding which aspects of the survey to tape. The pilot testing reinforced the habit and the importance of obtaining consent prior to asking the survey questions. I decided to tape the consent and explanation of the research because these were given verbally. *Dai*s' work narratives would also be taped. The survey questionnaire was seven pages long. As a researcher interested in qualitative data such as people's lived experiences, feelings, and thoughts, I was not interested in simply eliciting Yes/No answers. I wanted to know about their lives and their work. A Yes/No binary would not have given me that richness. However, this goal made the forms long, and at times some of the *Dai*s experienced fatigue. They also did not know why I wanted to know everything in detail. They would ask me why a Yes/No was inadequate and why their answers required a reason or an explanation. For example, they would say that they told the woman to take pains (to bear down), the baby was born, the placenta delivered, and the cord cut. But when I asked them to elaborate further, they would say, "*Behn,*[89] *I don't understand. The woman took pains and delivered. How else can you take pains? What else do you want to know?*[90] One *Dai* (NSMeh23, aged 70 years and practicing

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[89] In Gujarat female names have the suffix *behn*, meaning sister. This is a sign of familiarity and of having established a relationship. *Behn* means sister. For the males, one uses *bhai,* brother.

[90] The *Dais*' puzzlement is related to a different system of learning and understanding. Jordan (1993) noted that

> it is important to realize that for persons with little or no formal schooling, the purely verbal mode of knowledge acquisition is problematic. In everyday life, in contrast to formal education, skills are acquired by watching and imitating, with talk playing a facilitating role rather than a central role. Midwives in the

for 20 years) refused to describe her work because she said that she was feeling bashful, because we were all young and unmarried women. Based on this and other social boundaries, I did not add questions that would have explored the issue of work and health in greater detail.

Mehsana

When the survey questionnaire was ready for the field, I met with the health supervisor of Mehsana (see Map 5). Once the list of SEWA *Dai*s was made available, my two research assistants, a health worker, and I mapped out the interview time schedule for Mehsana. At the same time I presented the "Confidentiality Agreement"[91] (Appendix H), which had been translated into Gujarati, to my two research assistants and the Mehsana health supervisor. I explained the issue of confidentiality and the repercussions to the *Dai*s and the research if the confidentiality agreement were violated. Furthermore, I explained my obligations to the *Dai*s and to all participants in the research, including SEWA, and that the organisation would receive the aggregate data; the rest of the information, both taped and written, would remain in my possession for seven years and then be destroyed.

I began the surveys in June, the beginning of the monsoon season when planting occurs. One of the difficulties that I encountered when interviewing *Dais* at this time was their availability. Most of the *Dais* are daily wage earners who work on farms. To avoid delays in their work and productivity, I chose to interview them in their homes. The surveys were conducted while the *Dais* continued with their household chores. Because many *Dai*s cannot read or write, verbal consent was obtained and taped before each survey. The research assistants explained why I needed to get their consent, who I was, what my research was all about, why I was taping their interviews, and how the information was to be used.[92] Each survey took approximately 1-1.5 hours, depending upon the *Dai's* understanding of the questions, follow-up questions, and the types of answers elicited from the *Dai.* The answers were recorded in Gujarati, and I translated

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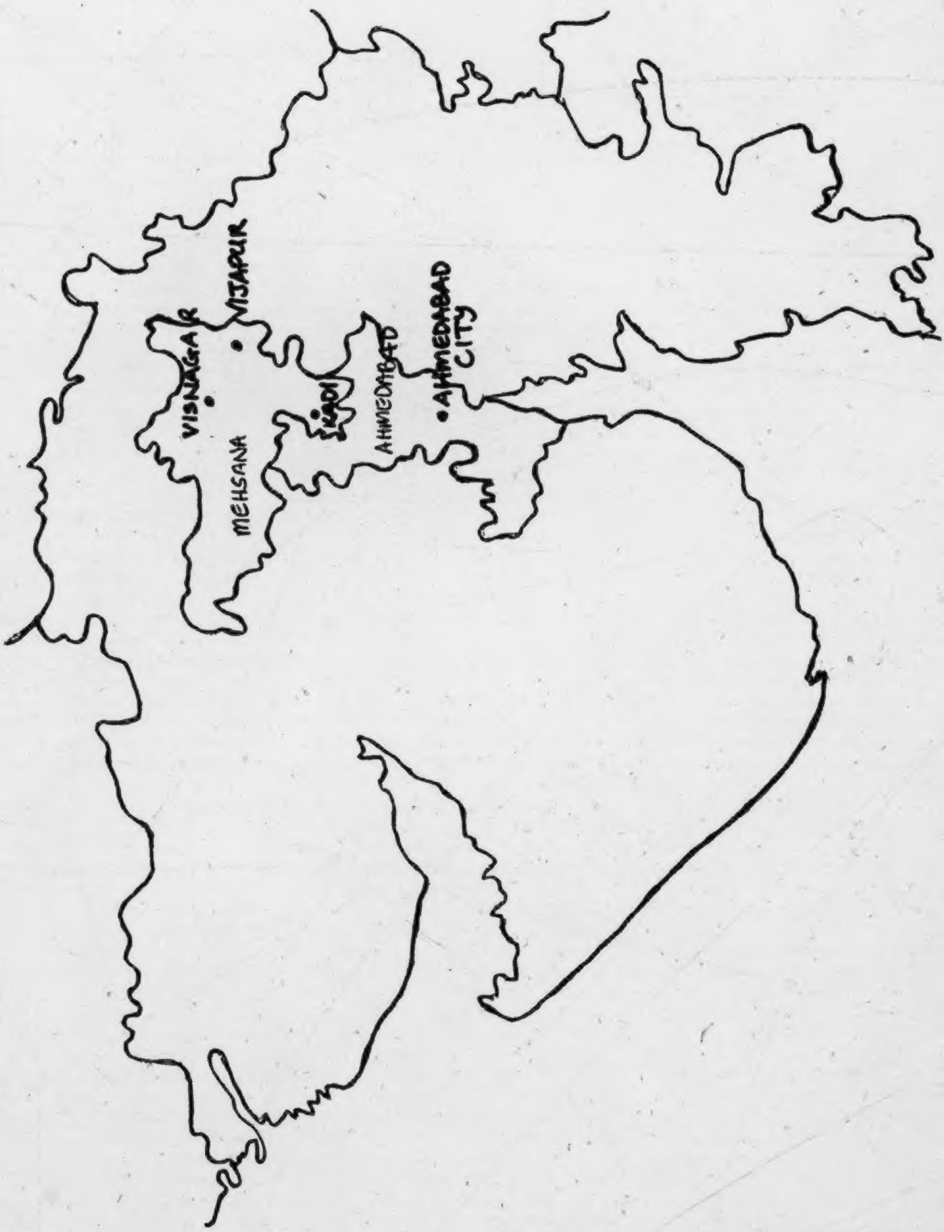
> traditional system are accustomed to learning experientially. . . . In the traditional system, to know something is to know *how to do it,* and only derivatively to know *how to talk about it.* Talk is never primary. (p. 178)

[91] Before I left for Gujarat to conduct my fieldwork, an ethics committee at the University of Alberta evaluated my proposed research. Maintaining confidentiality of the informants and preventing harm to participants are central principles of the ethics review. This is standard protocol at the University of Alberta.

[92] The *Dai*s were surprised when I took their consent before the questionnaire was administered. They felt that because it was an educational endeavour, what harm could there be? In fact, many of them would say that it was their duty to help.


VISNAGAR
VIJAPUR
MEHSANA
KADI
AHMEDABAD
AHMEDABAD CITY

Map 5. District of Mehsana and Ahmedabad City (fieldwork data, 1999-2000).

each completed survey form into English with the assistance of Dr. T. D. Gandhi, a key informant. Although retired, he knows of various individuals in the health ministry. He was able to advise me how to go about accessing data on demographics and health at the Ministry of Health.

Ahmedabad City

The process of initial contact with SEWA *Dai*s in Ahmedabad City (see Map 5) was similar to that in Mehsana. As with Mehsana, the SEWA staff did not have a list of non-SEWA *Dai*s. I acquired the list through the Ahmedabad city medical officer, who in turn referred me to the MO in charge of family planning in the city. His staff facilitated my access to these *Dai*s by contacting the staff of various family planning units and postpartum units and informed them of my research and time schedule. I chose to interview *Dai*s who were near large municipal hospitals and the Civil Hospital (Asia's largest hospital) to explore the reasons for reliance on *Dai*s even where medical facilities were within reach. The interview process for the survey was similar to that in Mehsana. For their time, effort, and willingness to share their knowledge, I gave a small honorarium to both groups of urban and rural *Dai*s. I gave the rural non-SEWA *Dai*s an honorarium in addition to return fares, and lunch and tea. To the non-SEWA *Dai*s of urban areas, I gave them honorariums and provided tea on-site. A few *Dai*s refused the honorariums despite my offers, citing duty. All these were done in consultation with the health care workers in the area. I sent the honorariums for the SEWA *Dai*s at later dates to Mirai Chatterjee. SEWA does not approve of individual honorariums because they may cause friction among the members. Due to personal circumstances, none of the research assistants was able to accompany me to conduct the interviews with non-SEWA *Dai*s. However, these women understood Hindi, and I was able to conduct the survey myself.

Conducting Semi-Structured Interviews

The in-depth (semi-structured) interviews were based on the objectives (above) of my research. They covered issues about health and work, including definitions of health, individuals' perceptions about their work and their work environment, relationship between *Dai*s and various health care members and *Dai*s' clients, *Dai*s' future role in the formal health system as perceived by various participants, including the *Dai*s, and remuneration. In the case of SEWA *Dais*, there were additional questions about the effect on their lives of being a member of a *Dai* co-operative and SEWA. In addition to the *Dais*, I interviewed some of their family members (preferably the decision maker in the family), *Dais'* clients, village functionaries[93] known as the Village Development Group, PHC staff (F/MHWs, F/MHS, MOs), state health officials, and officials at the international agencies, including the UN and the World Bank (in relation to the RCH programmes). I was unable to interview health officials in the central government.

Before conducting these interviews, I revisited each *Dai* village and introduced myself to the village functionaries such as the *sarpanch* (village head), *talati* (revenue collector), school teacher/principal, *aganwadi* (daycare) workers, tube well engineer, and the milk co-operative manager (if there was one present in the village), clients, and family members. My introduction occurred in two stages: first, through a letter sent via the *Dais* to the village functionaries and the PHC staff; and second, a face-to-face introduction following the letter, during which time we set up an interview date.

I interviewed these individuals using semi-structured questions (Appendix I). I wanted to obtain the relevant information for my study and yet retain the freedom to follow unexpected leads that might arise during the interviews. I also wanted the participants to have the opportunities to expand their answers in their own words. The research assistant and I used probes to encourage interviewees to reflect or expand on their ideas to obtain 'rich' description (Morse & Field, 1995). However, my field experiences indicated that probing could be a double-edged sword: on the one hand, it enabled the interviewees to reflect; on the other hand, there were those who became defensive when probed, accusing us of disbelieving them.

Questions were open ended, and each question focused on one theme—as Kvale (1996) noted, "the shorter the interviewer's questions and the longer the subjects' answers, the better" (p. 145). However, this format sometimes was not suitable. As my fieldwork progressed, I found that beginning each question with an explanation was helpful because it would set a context. As far as possible, I tried to sequence the questions in a logical and chronological order, although this was readjusted in the field, especially when the interviewee made statements that answered two questions.

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[93] I interviewed two deputy *sarpanch*, three *sarpanch*, six *aganwadi* workers, four *talatis*, five teachers, and three water bore operators. I interviewed two women of *Mahila Mandals* and one individual who was not in any formal group but was spoken of highly by everyone in his village. Village functionaries are individuals who are in the position of leadership either through election or by virtue of their work. These individuals make up the Village Development Group (VDG). Membership in this group includes the *sarpanch*, *deputy sarpanch*, *talati*, *aganwadi* worker, teacher, president of the milk co-operative, and water bore operator. These individuals are formally recognised. However, there are individuals who are not part of this group but wield power from behind the scenes. They include those who have migrated to the cities but return to their villages, non-resident Indians (NRI), and women of *Mahila Mandals*. These individuals as a whole oversee the welfare of the village. NRIs are Indians who have migrated overseas or individuals who are of Indian descent but not a citizen of India. Mahila Mandals were promoted by the GOI to encourage increased participation of women. It is another way to bring women's concerns to the forefront.

Interviewing Elites: Researchers, State Health Officials, UN and World Bank Officials

Researchers, state health officials, and UN and World Bank officials provided me with their agency's perspectives about their role in India's RCH programmes. They provided answers that I was unable to find in their official documents. In addition, I was able to access their recent publications about RCH and India. Such country-specific government publications may not be available in libraries outside India.

Interviewing elites, however, posed a challenge. Members in this group included Gujarat's state and district health officials, senior UN and World Bank staff, and academics. I felt that interviewing elites would provide me with valuable information about the overall organisation of India's and Gujarat's RCH programme. Marshall and Rossman (1995) noted that "elite individuals are considered to be the influential, the prominent, and the well-informed people in an organisation or community and are selected for interviews on the basis of their expertise on areas relevant to the research" (p. 83).

Because these individuals work under tight time schedules, I began contacting them two months in advance to request interview times and dates. This was done via fax and email and followed up by telephone. I faxed the GOI and SICI letters of introduction, the questions that I had developed, and a covering letter briefly explaining my research. With respect to interviewing elite people, Marshall and Rossman (1995) observed that accessibility can be facilitated through sponsorship. This was true for obtaining interview time with the Minister of Health. A member of his family facilitated the interview.

Despite these communications, I was unable to interview health officials in the central government and the World Health Organisation (WHO). I was provided with names of various individuals, who in turn referred me to someone else who they thought would be able to provide me with the data that I was seeking. The one important lesson I learned in the field was to be ready at all times. This meant having my questions and my tape recorder with tape and fresh batteries all ready so that I could conduct interviews at any time. My interviews with the Health Minister and UN and WB officials were fruitful and went well, in part because of my advance preparation and contact with them and because I accommodated their time schedules. Understanding their time constraints, my questionnaire was brief, although I tried to cover as much as I could. Because I was concerned that I might miss certain information during the interviews, I asked these individuals at the end of the interview if I could contact them again via email if there were any issues or questions that arose in future.[94] This gave me an avenue to maintain future communications to clarify points.[95] In fact, all seasoned researchers understand that "finding the right question to ask is more difficult than answering it" (Merton; as cited in Hammersley & Atkinson, 1995, p. 31).

Focus Groups

When individual interviews were not possible, as in the case with Primary Health Centre (PHC) staff and village functionaries, I used focus groups to collect data. This method is advantageous because it allows for group synergy, provides direct interaction (between respondents and researcher and between respondents), explores issues and generates hypotheses, has the potential to increase sample size, and provides open responses from the participants (Krueger, 1994; Stewart & Shamdasani, 1990). Other advantages of focus groups are that they are flexible and that the sessions are easily conducted, are inexpensive, and generate data quickly on short notice (Krueger, 1994).

Conducting focus groups allowed me to access a wide range of opinions quickly, and it saved time. Some of the focus group sessions encouraged greater participation because people felt safe in groups, and the response of one member would trigger responses from other group members. But these same advantages posed a challenge in many instances and became a barrier. I found that if I reminded them about the rules, there were those who became offended and would lose interest or become disruptive. In addition, the dominant group members would silence other members. There was also the gender issue: When the groups consisted of both men and women, the women would either hesitate to elaborate on their answers or not differ in their answers and would simply agree with the men. I therefore conducted two or three focus group sessions with various members of the same group, so that everyone would be able to contribute. Despite all of these challenges, the focus group data provided information about the political and social hierarchy in the villages and amongst the health care personnel, including which individuals were the visible power holders and who worked behind the scenes.[96] During one focus group discussion, an FHW who lived in the same village as the *Dai* corrected the *Dai*'s knowledge and contradicted the *Dai*'s information about the health status of the village.[97] The FHW was able to do this because, as a government health employee, she assumed authority. There was a clear display of social hierarchy.

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[94] Although the Health Minister was very accommodating, I did not ask this privilege from him because I knew that he handled three ministerial portfolios aside from that of the health ministry. In fact, with him I had no opportunity to send the questions in advance for his perusal. As with the senior level official, the interview was conducted when he indicated that it was convenient for him.

[95] Upon returning to Gujarat from New Delhi, I thanked them again through emails; and when I returned to Canada, I sent each a thank you card. This may sound excessive, but in the long run it is advantageous to keep all lines of communication open. It served me well because two years after the interviews some of them remembered me when I contacted them. I did this with many of the participants.

In addition to the village functionaries and the PHC staff, focus groups were used to interview SEWA's health researchers, health supervisors, and the CHWs of urban and rural areas. Focus group interviews with these individuals enabled me to gather qualitative data about the *Dais* from people who were 'reasonably homogeneous' (SEWA members, in their employment such as health care workers, SEWA employees, or residents of the same village). Together I conducted eight focus group sessions, and each focus group comprised five to seven participants from the same category.

Other Strategies for Data Collection

Aside from interviews and surveys, other strategies that I used to collect data included participant observation, consulting archival documents, and photography. Each strategy provided me with a context for the data I collected from surveys and interviews. For instance, the photographs became avenues to gain entry either to SEWA or to health care providers. For SEWA, photographs were documents of their work or records of events; whereas for the health workers, photographs were gifts because cameras and photographs are expensive and not readily available. The documentary data, such as Gujarat's annual socioeconomic reports, Five-year Plans of India and Gujarat, and publications on health by local NGOs and SEWA were all invaluable for providing me with an understanding of India's and Gujarat's health system, women's and children's health, women's work, primary health programmes, and future health directions. These sources enabled me to understand the position of the *Dai*s and the current health changes. Another invaluable source was my key informant, Dr. T. D. Gandhi.

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[96] For example, the GOI implemented strategies to bring about a balanced representation of women in the political realm through affirmative action. One such strategy is the reservation of political seats at various levels (village, district, state). At one of the villages that I visited, the *sarpanch* was a woman. When I introduced myself, it was not her but her husband who met with me. In addition, during the focus group discussion, it was he who came and not the female *sarpanch* (Mehsana, 1999). He was representing her. In another village a village functionary refused to come to the focus group because of caste differences. When I asked the question related to caste, most participants (except one FHS out of five, one MO out of six, and one *aganwadi* worker out of six) denied that caste was a factor that influenced either the access to care or health delivery.

[97] This is interesting because all the FHWs except one (not this FHW) said that the *Dai*s are the ones who are aware of the health status in the village and that it is through them that their statistics are updated. Although it is difficult to infer from just one set of interactions, it does show that the respect, trust, and relationship between the *Dai*s and the FHWs is not always as harmonious as it is made out to be. I also saw one FHS speak condescendingly to a few *Dai*s at her PHC when they came to ask for their payments. And yet it was the same FHS who during her interview praised the *Dai*s as intelligent, hardworking, and helpful and indicated that they should be paid more than Rs. 20 (Mehsana, 1999).

Participant Observation

My visits to various rural and urban health facilities and observations of health care personnel at work gave me a knowledge of the facilities and the resources that are available. I visited two urban hospitals in Ahmedabad, and in one I observed the labour and maternity wards.[98] In addition, I was also able to observe Caesarian sections, the operating room, and women's after-care. I was invited to people's homes and observed how individuals of various socioeconomic strata lived, including in the slums in Ahmedabad and the villages in Mehsana. All of these experiences were documented.

I wrote down my observations during the interviews, noting the context. My observations included observing facial and verbal cues of the participants and those around them (if applicable). Writing on the spot was not advisable at times because participants became suspicious and wanted to know what I was writing. They would feel constrained when they thought that I was 'monitoring' their behaviour.[99] On a few occasions SEWA women took the book away from me and tried to read what I had written, and at other times they peeked over my shoulder and tried to read. Depending on the situation, I either wrote in detail or just wrote a few words in my book. I wrote observations during the weekly and monthly health meetings, paying special attention to the role of hierarchy. I took minutes during the discussion of the planning of the SEWA *Dai* School.

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[98] I was able to gain access into these wards again due to the gynaecologist whom I met at the conference and who is related to the Health Minister. However, this facilitation came about through SEWA. This physician had done some volunteer work for SEWA and got along well with the organisation. It was after this meeting that I came to know that she is related to the Health Minister.

[99] Observing and recording were important because of the South Asian behaviour code. For example, a *Dai* was upset with the payment amount, and her expression reflected that. A few days later when I asked her how she felt about it, she immediately said that she was satisfied with the payment because it (her work) was the work of God (NSMeh29). Another example is how the SEWA women would present the image of the organisation to outsiders. Because at any one time there would be visitors from overseas who came to observe SEWA's work, the SEWA women presented and reinforced the accepted version of the organisation and did not convey their unhappiness or frustrations.

Other observations included *Dai* refresher courses provided by SEWA health supervisors and by the biomedical health personnel. I was unable to observe either the SEWA or the biomedical *Dai* training sessions because these were not held. The sessions were under review in the context of RCH. I visited various subcentres, PHCs, and the Community Health Centre (CHC) of rural Mehsana; and a municipal hospital, the various family planning units (FPU), and the post-partum units (PPU) in Ahmedabad City.

The observations of these facilities enabled me to gain a better understanding of the various health facilities and services in both the rural and urban centres. The observations, collected either through participating or observing, enabled me to understand the realities of the people. For example, one of the common complaints of villagers and the health officials (state and district) was that the health workers of the rural regions were not living on-site in the quarters provided. Because of this, villagers suffered and did not have access to health care. Health care officials stressed that the government was providing all the necessary infrastructure to meet the villagers' health needs and that the fault lay with health caregivers. After visiting some of the sites and observing the physical conditions at these sites, I understood the reasons why the health caregivers were reluctant to stay.[100]

Because I was there longer, many times when I sat in the foyer of the SEWA building I was able to observe these discrepancies.

[100] I wanted to understand the difficulties faced by these health care workers and the reason why many did not want to stay at the quarters. I stayed at three PHCs for an average of 3 days in each. At one PHC, I stayed in the quarters of the Ayurvedic doctor while he was away while at another, I stayed in the consulting room after clinic hours as there were no suitable quarters. At the third PHC, I stayed in one of the empty rooms that was originally a staff office. At each of these places I was assisted by the various health care workers with temporary bedding. There were no cooking facilities at any of these places and so I lived on the generosity of the villagers who invited me to their homes for all three meals. The FHS at one of the PHCs (located at the truck stop) was unhappy when I decided to stay. I had received permission from the MO of that PHC. Her reason was precisely that there were no cooking or bathroom facilities for me. However, I think it is because she was concerned that I would come to know that deliveries were not conducted at the PHC, which she had said occurred. During my first night, a woman in labour came but she was told to go to the private doctor because there was no water or electricity at the PHC at night. There were no streetlights and so it was not safe to be out at night. This was especially the case at one PHC, which was located near a major truck stop. The other PHC was located away from the main village while the third was in the midst of the village. Water supply

Participant observation added more layers of data to my research. Documents or data from interviews and surveys could offer a 'snapshot' in time instead, and the observation of live interactions could generate insight into the complexities of human interactions. For example, my observation of the interaction between the FHW and the *Dais* gave me a sense of the potential underlying competition of knowledge and the establishment of authority. My observations during SEWA health meetings showed that decision making even in an egalitarian organisation may not always be based on consensus. Participant observation shows the dissonance between reality and the ideal in every situation of human interaction.

Archival Documents

I began collecting documents at the beginning of my fieldwork. My first source was SEWA and its previous Annual Reports. I was able to access copies for each year from 1988 to 1998. These were excellent sources because they traced the progress of SEWA's work during the past 10 years. I was able to obtain SEWA's publications relating to women and work. In addition, Mirai has published widely and presented papers at numerous national and international conferences. She placed a wide selection of documents relating to women's health at my disposal, in addition to SEWA's 1991 *Dai* study. The latter allowed for comparison of the socioeconomic data in my study. I was able to obtain further material on women's health in India and Gujarat from the Ford Foundation, the Research Centre for Anusandhan Trust (CEHAT), an NGO based in Mumbai,[101] the Gujarat Institute of Development Research (GIDR), and CHETNA, an NGO based in Ahmedabad.

The Foundation for Research in Health Systems (1997, 1998), an Ahmedabad-based NGO, does studies on various health issues and publishes an annual report entitled *Health Monitor*. The Population Research Council in Vadodara, Gujarat was an excellent source for population data, and I relied heavily on its *National Family Health Survey* (1993) in my discussion on the health profile of the population of Gujarat. I was able to interview Dr. Gandotra, who is the Director of the Council and one of the researchers of the above

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came twice a day at two PHCs and once at one for about an hour. Roofs leaked during the rainy season, and toilets did not have the proper flushing system. Many of them were broken. Power supply would fluctuate and power outage was common.

[101] I was able to access more health literature through CEHAT subsequent to my fieldwork.

publication. An excellent source was the *Gujarat Human Development Report* (Hirway & Mahadevia, 1999), which contained an in-depth review of Gujarat's development using a multifactorial approach (including women's work) to population health. I relied heavily on this report. Dr. Mahadevia (personal communications, January 15 and November 18, 2001) clarified various population data for me. Other sources for Gujarat population health, long-term health plans, and socioeconomic and historical background were accessed from government publications including *Gujarat Gazette* (GOI, 1989, 1991) and from individual ministries.[102] The nurse tutor at the State Institute of Health and Family Welfare (SIHFW) gave me copies of previous *Dai*-training curricula.

Libraries in Gujarat could be accessed with a formal letter of introduction and an insider's contact from the institution where the libraries were situated. The different systems and lack of documents meant that I had to trace them from the original source. Other sources included UNICEF (India and UNICEF partnership on RCH), the World Bank (publication on RCH funding and its position), UNFPA (coloured map of India showing literacy, gender ranking, population distribution, and poverty), UNDP and the Population Council, all based in New Delhi. I also consulted the documents published by the Ministry of Health and Family Welfare (MOHFW), such as the Community Needs Assessment (CNA; GOI, 1997b) and the *Bulletin on Rural Health Statistics in India* (MOHFW, 1992 to 1997). The latter provided me with data on rural health and structure, and the CNA gave me the historical background and India's approach in implementing RCH within its HFA framework.

Some Issues Considered During Interviews: Personal Attributes and Cultural Beliefs

The researcher is the instrument in qualitative research. Aside from designing the instruments to use and being the implementer, personal attributes and cultural beliefs such as loss of face, caste, and politeness all affected my entry and access to data in the field. Marshall and Rossman (1995) reminded us that researchers are not expected to hide the cultural values that guide their decisions, but they must be careful not to impose them on the participants. This leads to awareness that research does not occur in a vacuum but is linked to personal interest, values, and experiences.

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[102] These include the Directorate of Economics and Statistics and the Ministry of Health.

Politeness

Being a South Asian female from Canada, able to speak Hindi, and of a Brahmin caste influenced the way that people perceived me, their willingness to be interviewed, and what they wanted to tell me. Although people acknowledged me as a South Asian, they also considered me a foreigner with a different set of values and not as one of them. In the South Asian worldview (and Asian culture in general) it is considered bad manners and a loss of face when someone criticises or points out the negatives about his/her environment to a guest.[103] I found this trait common amongst many participants ranging from state and district health officials to the *Dai*s. The chief district health officer (CDHO),[104] for example, made the following observations about the state of the Primary Health Centres (PHCs):

> *All the PHCs are well equipped. They have all the primary health drugs in stock, and the doctors do not experience any shortages for equipment. There are adequate facilities for deliveries, and if the doctor wants to perform any minor procedures, then everything is available. So this is what I mean when I say that the services are available and the health infrastructures are there.*

However, a village functionary[105] (teacher/principal) of one of the villages commented on the state of health care as follows: *"No we do not get good services or adequate treatment from*

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[103] Dr. T. D. Gandhi provides a case in point. When he found out that my surveys were not accurately translated, he immediately volunteered to assist me to redo them. Dr. Gandhi refused monetary payment and insisted that he was merely doing his duty. He said:

> I want to preserve the good name of Bharat [India]. You are a guest in my country. It is a matter of honour for me to ensure that despite all the difficulties you are experiencing, you should at least have a good impression of India to take with you when you return to Canada. It is my duty to ensure that (1999-2000).

[104] District Health Officers are usually medical officers promoted into administrative work, unlike some of the government functionaries such as the Commissioner of Health and Secretary of Health, who are graduates of the Indian Administrative Services (IAS), a legacy of the colonial era. Every year hundreds of individuals apply to sit for the exams, and those who qualify are then sent to different ministries to be trained as bureaucrats. They are the cream of the crop, the future leaders. The CDHO is a medical doctor.

[105] A village functionary is someone who is a member of the Village Development Group. Individuals in this group include the teacher, *sarpanch*, *talati* (revenue collector), bore operator, president of the milk co-operative, *aganwadi* (nursery worker), and other informal leaders of the village. They work towards the development and welfare of the village. According to the teacher/principal, if someone requires medical treatment, they have to travel to Kalol, Kadi, or Mehsana, which are 20, 18, and 25 kilometres away, respectively. He noted that individuals pay fares of Rs. 150-200 to travel in an autorickshaw to these places because the price of diesel is high.

the government health care workers including the doctors. People do not trust them and therefore the villagers seek treatment at a private clinic" (TeachbhaiVillA).

A SEWA-trained *Dai* who had been practising for 10 years had not received the government-allocated funds of Rs. 20 for each normal delivery that a *Dai* conducts. She had not been issued the ID card from the district health office even though she gave her SEWA certificate to the FHW as proof. When asked how she felt about this, she said, *"It does not matter, as I am doing a work of service, and I am happy that I can help people. It does not bother me because I receive blessings from people"* (SMeh22). A medical officer (MOj) who was transferred from a large urban hospital to one of the PHCs[106] was unhappy with his transfer, but during the interview he indicated that he was satisfied with this work and liked the environment. This is one of the dilemmas that I encountered during my data collection: which statements reflected the true reality of this individual or the situation? This MO was aware that that he had changed his statements, and to an outsider[107] this may seem odd. But when both observations are contextualised in the South Asian (and Asian) worldview, his behaviour becomes clear. First, a South Asian is taught that complaining is a sign of greed and dissatisfaction and does not reflect well on the individual. Second, implicit in a South Asian's behaviour and related to the first observation is honour. *Izzat ka sawal* (a matter of, or a question of, one's honour) and the fear of losing face cannot be emphasised enough. When he changed his statements, this MO, and many like him, were merely maintaining their *izzat* to an outsider. My familiarity with the South Asian worldview was clearly an asset to my research.

If it is considered bad manners for the host to complain to the guest, then it is equally unacceptable for the guest to disbelieve or question the host's statements or observations. Being polite is a reflection on one's upbringing, implying that one has been raised well.[108] Throughout my research I had to strike a balance between probing and challenging the information of the interviewee and accepting what was being told to me. Too much probing gave rise to statements such as, "*Arre behn! Why are you asking me the same question again? I have already told you that*"; or there would be a change in mode of engagement from being open to suddenly being polite and agreeing with me, another sign of either politeness or anger masked with politeness. All these social mores and personal attributes shaped my data-collection methods and the type of data that I was able to access.

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[106] This is one of the PHCs where I stayed. This PHC covers 14 villages with a population of 35,314 (1999).

[107] I include myself in this category. In the field I was not operating from my cultural knowledge but from the knowledge of a researcher. When this occurred, I was uncertain as to which statements/observations were true reflections of their reality. I realised that the social code of honour, politeness, being satisfied, and not being greedy were values that influenced people about 'saving face.' It is not that Asians do not complain, but adhering closely to the ideals is one way of building one's reputation and standing in the community.

[108] My parents (both South Asians) instilled this value in me when I was growing up in Singapore. One area where this rule was strictly applied was food. This lesson served me well when I was in Gujarat. People were often amazed that someone from Canada (whom they perceived as being accustomed to eating "good food") enjoyed eating their "humble food" such as *dhal* (lentils), rice, *rotla* (flat unleavened bread made of millet), and curry (usually vegetarian). *Rotla* is usually not served to guests because it is considered coarse, everyday fare. Instead *roti*

Although people did not ask about my caste directly, they would try to ascertain it through my research assistants by asking my surname.[109] My caste allowed me to have access to individuals of both upper and lower castes: The upper caste saw me as an equal, and the lower caste saw me as someone who did not keep caste boundaries when I sat or took meals with them.

Limitations

Like all studies, this research has certain limitations. One has been the environment in which the research was conducted. Conducting research in a foreign country is both challenging and rewarding (Ogilvie, 1993). Although I had conducted qualitative research in the past using open-ended questions, this process was entirely in English. Furthermore, it was conducted in Edmonton, Canada. I did not experience the language barrier or the isolation that I experienced in Gujarat. Gujarati was an entirely new language to me in which I was not fluent. This made communications with those who could speak only Gujarati difficult. I therefore had to rely on the expertise of translators. The language barrier had an effect on the length of time it took to translate the questions for the interviews and the survey to ensure clarity and effectiveness. This in turn had an effect on my time and research finances.

(unleavened bread made of wheat flour), *paratha* (flat bread made of wheat flour and pan fried), and *puri* (flat bread deep-fried) are preferred.

[109] Surnames provide a clear indication of one's caste. However, these surnames differ in every state. The surname of someone of a Brahmin caste in Uttar Pradesh (UP), where my parents are from, is different from that of someone in Gujarat. When I went to Gujarat I did not know what these were. It was only after staying there for 11 months that I became familiar with the various surnames that belonged to different castes. Also, in each caste there are further subdivisions and hierarchy. So even within the Brahmin caste there is a hierarchy of high and low, known as *jat or jati* (loosely defined as subcaste) and *gotra* (ancestral lineage).

While I was in Gujarat, communication with my advisors was limited, and on many occasions I could not wait for their feedback because I needed to act quickly.[110] What could have assisted me was to have a link with someone in the academic setting in Gujarat, someone who was familiar with qualitative research and the issues related to the process. Despite this limitation, I was able to conduct and complete my fieldwork based on my own judgement and SEWA's guidance.

A second limitation is related to the fact that this study reflects only a single moment in time. Although I was able to observe deliveries conducted by *Dai*s from each group in Mehsana, this provided more of a 'snapshot' than a trend. It is difficult to generalise data obtained from few events to a larger population. This is because practises vary depending on the regions (urban versus rural), *Dai*s' experience, length and type of apprenticeship of *Dai*s, and the family's beliefs and traditions. Nonetheless, data from my observations provided me with valuable insights about *Dai*s' work. I understood the constraints under which *Dai*s work when they attend home births. I observed how they improvised to ensure that delivery was conducted in a clean and safe environment. I also saw the use of the *Dai* Delivery Kit, the making of *utkaaro* (see list for terms), the disposal of placenta and cord, caring of the newborn, and assisting the new mother.

The third limitation is connected to the geographical regions where the surveys were conducted. Whereas the survey of non-SEWA *Dai*s was conducted in three *talukas*[111] (see Map 5), those of SEWA were conducted in only one *taluka.* The reason for this was that most of the SEWA *Dai* membership was concentrated in one *taluka.* This could have an impact on the findings because the population demographic changes from one *taluka* to the next and even within villages. However, my data analysis shows that there are no distinct variations among the *Dai*s despite the regional demographic variations. Their concerns about payment, understanding of their work, and skills are similar across different settings.

The final limitation is related to my decision to use snowball sampling, also known as selective sampling. Snowball sampling (Bernard, 1995) in this research was the most practical technique because I was able to save time. I was able to have immediate access to the *Dai*s, which otherwise would not have been possible, especially in an environment in which gaining trust and access had to be established before conducting my study. The decision to use snowball sampling in the selection of the *Dai*s for the research could affect the results. Snowball sampling is limiting because it depends on those involved and their referrals of other potential participants, which could lead to the inclusion of some *Dai*s and the omission of others and limit multiple perspectives.[112] Despite the limitations of snowball sampling, I believe that I was able to access a wide cross section of *Dai*s of varying experiences, beliefs, practises, income, and castes.

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[110] I had access to SEWA's fax and email services. But because these were heavily used, sometimes I was unable to use them sooner. Later on I was able to have my own email account.

[111] Each district is divided into *talukas* (subdistricts) and villages.

Ethical Considerations

The ethics review at the University of Alberta, a standard practice for all research involving human subjects, prepared me for some of the potential ethical dilemmas that I could encounter in the field. To ensure confidentiality, I developed a 'Confidentiality Agreement' document signed by the two research assistants and the SEWA health supervisor. This was done because the research assistants were also members of SEWA, and they were interviewing SEWA *Dai*s. The health officers at the district office did not sign the agreement because they were not involved in the interviews except in providing the names of the *Dai*s. Another way that I ensured confidentiality was to conduct the interviews privately so that the *Dai*s, or whoever the participants were, did not feel uncomfortable.[113] Sometimes this privacy was invaded, especially if there were curious individuals who wanted to know what I was taping. However, many understood when my research assistant explained to them what I was doing (once they came to know the topic of the interview) and left. With all of the participants, I switched off the tape if they felt that they did not want the particular information recorded, and I offered them this courtesy in advance of the interview. I use pseudonyms to maintain confidentiality of participants to prevent any harm, especially those whose testimonies were deemed negative either by health officials or SEWA. However, I identify Mirai and other SEWA leaders because they are elites and their testimonies represent the philosophy of SEWA work. They also granted me permission to use their names in my dissertation.

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[112] During the survey the *Dai*s or the village women who would sit and listen would ask if I would be interviewing "so-and-so" *Dai*, who also conducts good deliveries. Her name would not be on the list provided by the district health office. One reason could be that she was not a "trained *Dai*" or that she conducted deliveries only in her own extended family.

[113] In the focus group, however, I assured the participants that the data would only used only in my research and that no one would have access to it except myself. This was important if the health care workers provided information that was sensitive in nature and were concerned that I would inform either the state health officials or the CDHO.

Consent was obtained verbally from the *Dai*s at the beginning of the survey or the in-depth interviews because the majority of them were unable to read or write. If there was a lapse of time between the interviews, I would ask for their consent again.[114] Verbal consent was also elicited from the health care workers, medical officers, village functionaries, *Dai*s' clients,[115] state officials, and those in New Delhi[116] after explaining the objectives of the research to them. In the focus group discussions, I would ask each for his or her consent before I began. With all participants except the elites, who perceived themselves to be higher status than I and therefore not beholden to me, I emphasised that this should be voluntary. For the translations and the transcription of data, I reinforced the importance of confidentiality verbally on the basis of trust.[117]

Post-Fieldwork: Data Management and Analysis

Triangulation of Data

I have discussed some factors that influenced my data collection in the field. Issues such as personal attributes of the researcher and cultural values all affected the type of data I was able to collect. Other factors include my lack of fluency in Gujarati, reliance on others to implement the data-collection tools, and the skill of the transcribers and translators. Regional differences in pronunciation and changing timelines also affected the type of data available. Because I was aware of their impact on my research findings, I took steps to minimise their effect. To ensure reliability, I triangulated my data from multiple sources in three ways. First, I posed similar questions to individuals in each category; that is, health care workers (subdividing them further into FHWs, FHSs, and MOs), village functionaries, family members, and so on. Second, I posed similar questions to members in each category in different rural regions. And third, I tried to compare the interview information with my observations and documentary data. In qualitative research, however, multiple and alternative explanations are expected because the research environment is not controlled, and therefore different perceptions by individuals about the phenomenon under investigation are to be expected (Hammersley & Atkinson, 1995; Marshall & Rossman, 1995; Shi, 1997). This is based on the assumption that social realities are continually being reconstructed based on the experiences and perceptions of individuals.

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[114] When I did this they would be puzzled because they felt that they had given their consent at the previous session. My research assistants would then explain the reason for doing this. I also took their consent when taking photographs.

[115] In this instance, the *Dai* would take me to the woman whom she had assisted in the delivery and explain to her the purpose of my study. I did not have the opportunity to meet with her beforehand. In this case, it is questionable whether I truly received her true consent or whether she felt obligated and "put on the spot" by the *Dai* and me. Either the *Dai* would leave on her own accord, or I would request her to do so, using the same explanation of privacy that I had practised with her.

[116] For these individuals I took it that their consent was implied in their agreeing to meet with me and answer my questions.

[117] I explained to these individuals the obligations and ethical rules by which I was operating. I was able to get my first transcriber to sign the Confidentiality Agreement, but subsequently it was difficult to do this, so I elicited a verbal agreement. Another reason that I hesitated was the fact that although this may be a common practice, in Gujarat there was always the potential that the individual might feel affronted that I had asked him or her to sign a document for confidentiality. Before even eliciting a verbal agreement, I had to contextualise my actions.

Regional Differences

Regional differences in pronunciation and language between the urban and rural meant that certain Gujarati words posed some difficulties for those who were transcribing the tapes. For example, the numeric 100 is pronounced as *sou* in the city, but in the villages of Mehsana it is *hou*.[118] Thus some of the transcribers either left a space or replaced it with another word that they thought the interviewee had said.

Language Constraints: Transcriptions and Translations

Because I am a non-Gujarati speaker, language was a barrier that affected access to data. I relied on others to conduct, transcribe, and translate the interviews and the surveys. The interviews were conducted in the local dialect because I felt that this would enable people to speak freely, be at ease, and allow them to express their thoughts well. Bilingual speakers then transcribed and translated the data on the tapes from Gujarati into English. *Dai*s, their families, their clients, the villagers, the health care workers (SEWA and government), and the SEWA researchers and supervisors were interviewed in Gujarati. Some of the interviews were conducted in Hindi (my mother tongue), and these were translated and transcribed into English by myself. Individuals in this group were the Gujarat Health Minister and the SEWA Health Co-ordinator.

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[118] Even in the villages of Mehsana, there are variations.

The interviews were conducted in English with those who could speak and understand it, and these were recorded verbatim. In this dissertation, quotations from all have been 'cleaned up' to ensure clarity for the reader, but as far as possible I have tried to maintain the intention of the speaker.

The quality of the transcriptions and the translations has an impact on my research analysis. Accessing bilingual speakers was challenging because there was no formal agency that provided this type of service. Referral to these bilingual speakers was always through word of mouth. Although I paid these individuals to do the task for me, the implicit message was that they were doing me a favour, and in doing so they too were performing *poonya ka kaam*[119] (work of blessing). Because it was an informal system, in many instances these individuals were either unable to adhere to the timeline or unable to complete the work, and I had to find someone else to do this work. Multiple translations by various individuals meant that the quality varied. One of the ways I tried to address this was to read through the transcripts with a linguist. Another technique I used to ensure accuracy of the transcriptions was to ask one of my research assistants, Mangla,[120] to listen to the tapes with the transcripts.[121]

Limited English vocabulary and knowledge of its subtle nuances meant that there were English words that were literal translations of the Gujarati. These English words did not convey the actual meanings in the context of what was being said and were unsuitable in the sentence. One example will illustrate this. According to the FHWs, training is given to the *Dai*s so that they will recognise the risk factors, avoid complications during birth, and prevent death of the mother or the child. In Gujarati if complications occur during the delivery that lead to adverse outcomes such as death, then FHWs and clients call this *suwaver bigaro*. The literal translation of *suwaver bigaro* is "pregnancy/delivery [is] spoilt or gone bad."[122] Therefore the translators would write the following: *"The Dais are told to refer women to hospitals if the pregnancy is risky to prevent the delivery from being spoilt"* instead of "to prevent complications and adverse outcomes during delivery."

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[119] In this instance they saw me as a lone stranger, helpless and in difficulty, so their *poonya ka kaam* is linked to their efforts in assisting me, especially because I had no support system, to overcome my difficulties.

[120] She was one of my research assistants. She is multilingual in Hindi, Gujarati, and Marathi.

[121] We did this randomly, so not of all the transcripts underwent this procedure. This was partly because of lack of time, and, as noted, the transcripts were often delayed.

[122] In some ways this literal translation is understandable because the same word in the Gujarati conveys different states and, at the same time, the same meaning. For example, *bigaro* is used in *gaadi bigaro* (something is wrong with the car), *khana bigaro* (food is spoilt), *aadmi bigaro* (he/she is not in a good mood or not behaving according to the accepted social rules), and *kaam bigaro* (work did not go as planned, did not achieve the desired results). So although *bigaro*'s literal meaning is *spoilt*, when used in different contexts its meaning changes, but the underlying meaning remains the same in all: unable to achieve the desired goal because the object or situation was not

I tried to address this in a number of ways. First, I made a thorough reading of the texts with the linguist. Once I had done this for a while, I was able to recognise some literal translations of words and whether they were appropriate in the context of the sentence. If they were not, I was able to replace them with the appropriate English words without changing the intended meaning. The second strategy was to be present during the entire interview process even though Mangla (and not I) conducted the interviews. This enabled me to remember what the interviewee had said during the interview. If I did not understood what she/he meant, I was able to clarify with her/him using Mangla's help. The third strategy was to do the translations myself. This involved Mangla's listening to the Gujarati tapes or reading the transcripts and explaining them to me in Hindi while I wrote in English. Alternatively, I would listen to the Gujarati tapes, write the translations in English, and then check them with Mangla.[123]

Data Analysis

The central focus of the analysis in this study is work and how it effects *Dai*s' health. Health is defined as work and income security; that is, whether the *Dai*s and those around them perceive that *Dai*s have these. The second focus of health is social health: Do the *Dai*s and others perceive that *Dai*s are empowered? Are the *Dai*s able to determine the direction of their work; for example, control their level of remuneration? To what extent are the *Dai*s involved, and are their contributions recognised by the formal health care system?

Jorgensen (1989) defined *analysis* as "breaking up, separating, or disassembling of research materials into pieces, parts, elements, or units" (p. 107). LeCompte and Schensul (1999) described analysis as the process in which the data are reduced to manageable form, enabling the researcher to "tell a story about the people or group that is the focus of their research" (p. 2). Marshall and Rossman (1995) noted, however, that

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in optimal state. In the English language, however, there are words such as *complications*, *spoilt*, *adverse outcomes*, *malfunctioning*, *bad*, *wrong*, *incorrect*, and so on to describe the same state in various scenarios.

[123] At the end of my fieldwork, I was able to understand conversational Gujarati, if it was spoken slowly.

> data analysis is a messy, ambiguous, time consuming, creative and fascinating process. It does not proceed in a linear process; it is not neat. . . . It demands a heightened awareness of the data, a focused attention to those data, and an openness to the subtle, tacit undercurrents of social life. (pp. 111-114)

My preliminary data analysis occurred in the field while conducting the surveys. I would write down certain key themes or issues that arose during these surveys to include them in my semi-structured questions. In qualitative research it is suggested that preliminary data analysis be done in the field before proceeding with further data collection. However, apart from writing keywords and themes, in-depth field analysis was not possible due to time constraints. Ogilvie (1993) experienced similar time constraints during her study in Nepal. The bulk of my data analysis began after my return to Canada.

Because my goal was to understand the relationship between the *Dai*s' work and their health, my analysis focussed on the responses of various individuals to *Dai*s' work. As far as possible I asked each group similar questions, but this was done in such a way that they were appropriate to the group. For example, I asked the health care workers what types of ill health they observed and treated in the villages. The family members (*Dai*s) and village functionaries were asked about the prevalent ill health/diseases they saw in their villages. In this way I was able to check the data of the health care providers with the residents and with my observations. I believe, however, that each of the participants was speaking the truth based on his/her perceptions of reality and experiences, and that was my starting point. Outliers were not ignored but provided one of multiple realities.

The first step of analysis began with grouping similar individuals in each category, such as health care workers, family members, village functionaries, SEWA women, and *Dai*s' clients. In the health category I further subdivided the individuals into MOs, FHSs, and the FHWs. I took similar steps with the *Dai*s' surveys, dividing them into urban SEWA and non-SEWA and rural SEWA and non-SEWA.

In the second step I collated the responses of individuals in each category on similar questions. I continued to maintain the subdivision of the health workers as above. As for the *Dai*s' survey, I grouped their responses to each question based on the above division. I highlighted the recurring themes, events, understanding, and words that were common in the

Dais' work narratives. Words and themes that were uncommon were placed in the margins with the *Dais*' names at the side.

The third step involved searching for common themes and patterns in each category. In the case of the health care providers, this involved searching for common themes in each subset (see above). The third step enabled me to observe whether there were any emerging patterns. Even though I searched for common themes, I did not exclude the outliers; that is, responses that were uncommon compared to the rest. A similar process was applied to each of the groups interviewed, including the *Dai*s' responses in the survey questionnaires. In the *Dai*s' analysis I checked for differences between SEWA and non-SEWA *Dai*s in both areas. In addition, I highlighted stories that the *Dai*s told in their work narratives, which I have used as vignettes to illustrate their points. The goal of the work narratives was to capture the *Dai*s' experiences in both normal and complicated deliveries. However, sometimes this was not possible because the *Dai*s were eager to share other events such as their paranormal experiences.[124]

In this study, data analyses were done manually. Although computer programmes are useful in sorting data, they are not sensitive to cultural nuances such as are present in my research data. The photographs and my observations recorded as fieldnotes assisted me in contextualising my results so that they made sense relative to the themes that were emerging. This comparison was crucial because, as noted, there is a dissonance between what respondents say to an outsider and the actual reality. It is not that individuals want to mislead the researcher; they are operating from their own cultural worldview. As a researcher, I want to ensure that the information that I obtain presents all sides of an issue.

My analyses therefore occurred at two levels—examining the content and identifying the themes, but keeping work as the central focus throughout. In doing so I was attempting to ascertain whether there were any emerging patterns and themes. LeCompte and Schensul (1999) identified eight different ways that patterns may emerge: declaration, frequency, omission, similarity, co-occurrence, corroboration, sequence, and a priori hypothesising. In my analysis, patterns occurred through frequency, similarity, corroboration, and co-occurrence of words, reality, and feelings. Although outliers did not fit into any of these categories, they revealed an alternative reality.

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[124] These include the spirit of the deceased child haunting the *Dai*. One *Dai* said that she had delivered a child with only one eye, and it was a sign that the child was possessed by an evil spirit. This posed a dilemma for me as a researcher. As a South Asian I grew up with the belief that paranormal experiences are another aspect of reality, and when these *Dais* recounted them, they were entirely credible to me. However, as a researcher in public health sciences, I would not be provided with the factual data of these unusual experiences that would indicate the *Dai*s' level of skills and biomedical knowledge that would assist me to suggest concrete policy changes.

Interpretation of Data: Making Sense of It All

Interpretation, according to LeCompte and Schensul (1999), is the goal of analysis; it is a process by which meanings are given to the analysed data, "what they say about the people, groups, or programs that the ethnographer has been studying; . . . permits ethnographers to describe to a reader what the story means" (pp. 3-5). Marshall and Rossman (1995) felt that "raw data have no inherent meaning; the interpretive act brings meaning to those data and displays that meaning of the reader through the written report" (p. 113). The researcher has the freedom to decode these taken-for-granted events and apply new meanings to enhance our understanding and challenge our biases, but Thomas (1993) contended that interpretive work must do more—it must be a vehicle for change so that "it also identifies ways by which alternative interpretations of cultural symbols can be displayed" (p. 43). Berg (1998) and others (Bernard, 1995; LeCompte & Schensul, 1999; Marshall & Rossman, 1995; Morse & Field, 1995; Wax, 1985) identified good research as something that identifies areas for change, seeks policy relevance for that change, and engages the audience. Hammersley and Atkinson (1995) noted that research is a social process through which knowledge is created to bring about change. In the end, critical interpretation challenges both the participants' and the researcher's social construct through continual reflection on the data and constant search for alternative meanings of familiar objects and events; and "in this sense, our results are never final, but only partial and always subject to rethinking. If done well, intellectual reflections create new ways of thinking" (Thomas, 1993, p. 45).

The goal of my research was to bring new understanding of *Dai*s' work. Data on *Dai*s' work exist, but they are found in broad percentages in terms of noninstitutional births. This type of data does not tell entirely what *Dai*s do or about their interactions with other health care providers. What is known, however, is that they are recognised as making significant contributions to the Gujarat health care system. This type of information does not inform us of the effect of their work on *Dai*s' health. Because employment and income are critical for poor women, exploring *Dai*s' health in relation to their work is crucial. Because *Dai*s are women workers, better understanding of their contributions should lead to concerted efforts by the

Gujarat government to formulate and implement strategies to address their health through the Reproductive and Child Health (RCH) framework. Multiple views collated from a wide cross section of the population about *Dai*s and their work legitimise *Dai*s' push for greater involvment at the policy level.

In interpreting the data, researchers must approach the information with "some scepticism and a willingness to consider that the participants in the study have ensured a particular presentation of themselves" (Goffman; as cited in Marshall & Rossman, 1995, p. 116), and must be aware of alternative explanations. Thomas (1993) noted that language is a form of power, because it symbolises events that either isolate or communicate one set of meanings and excludes others. Language has the power to name and organise things and to provide meaning to existing or new experience; thus all linguistic exchanges, and, for that matter, all interactions, give rise to domination that shapes our understanding and discourse (Bourdieu & Passeron, 1977). Bourdieu and Passeron noted that this power to name and provide meanings is more conspicuous in the "authority" of scholars, who proceed from existing realities while simultaneously naming and classifying new meanings. Thus Thomas observed that

> how we "hear" our data as they speak to us, and how we translate what we have heard into a set of messages for an audience, gives the researcher the power to define and transmit "reality." As a consequence, the discourse in which we write our results is as important as the language of the texts of the fieldnotes that we analyze. The critical ethnographer's goal is to examine both the language of our data and the language in which we speak about our data to identify those traditions, norms, institutions, artifacts, and other characteristics of culture that provide access into the netherworld of mundane life to unblock alternative metaphors and meanings. (pp. 45-46)

It is precisely to present alternative explanations about *Dai*s' work that I used various methods to interview different individuals. Furthermore, the inclusion of the various stakeholders has allowed the integration of micro- and macro-level observations about *Dai*s' work and health. The multiple perceptions that emerge will increase our understanding of the dissonance between the *Dai*s' reality and their ideals. The dissonance is between the *Dai*s' need for income, work, and health security and their continued adherence to social values and ideals. A second dissonance is the context of their work. Their work is valuable and needed, but it is not valued. Understanding the mismatch will augment the existing literature on *Dai*s' work while at the same time assisting

SEWA and other organisations to formulate strategies to promote *Dais*' visibility and empower them.

Conclusion

In this study, multiple perceptions of various individuals were collected through interviews (personal interviews or focus groups) using semi-structured questions (Appendix I). These questionnaires were designed specifically for each group. The *Dais* were interviewed using a questionnaire form that had both closed and semi-structured questions. The purpose was to collect their demographic data, work history, and information regarding their training and apprenticeship. The goal was to provide a complete picture of *Dais*' socioeconomic status, knowledge, and work. Two groups of *Dais*, SEWA and non-SEWA, were interviewed in urban and rural areas, to explore whether there were any regional differences in their experiences. Other data-collection strategies included participant observation and the consultation of archival materials such as documents published by the governments of Gujarat and India, UN agencies, the World Bank, and several non-governmental organisations (NGOs) in Gujarat. These documents provided me with the background materials to enhance my understanding of the changes that were taking place and of the various health programmes in India and Gujarat. Although the bulk of the data analysis occurred post-field, informal data analysis in the form of noting down main points or issues that I thought needed further investigation during the *Dai* survey enabled me to tailor the semi-structured questionnaires for each group.

My field experiences corroborate Shaffir and Stebbins's (1991) observations that fieldwork is one of the most challenging and difficult endeavours. Fieldwork involves the challenge of conducting one's work in an unknown environment, learning to negotiate with the participants, and at the same time ensuring that no harm comes to them. Research work usually benefits the researcher, although efforts are made to ensure that those who participate in the research gain from their involvement. The ethics guideline is one safeguard that allows the participants' needs to be taken into account and maintains a strong stand that no harm be done. Fieldwork challenges are often viewed from the standpoint of the researcher, who in most cases has uprooted himself/herself to explore a particular topic more deeply. However, the participants' difficulties are seldom discussed, except in feminist literature (Gurney, 1991; Lal, 1996; Patai & Gluck, 1991; Tomm, 1989; Tomm & Hamilton, 1988; Young, 1997).

The socioeconomic determinants of health framework (SEH) was used to analyse *Dais*' work; specifically, their social and economic status and their position within Gujarat's health care system and SEWA:

- What are the factors that influence the value of their work apart from the financial remuneration? What impact do these factors have on the *Dais*' overall perceptions of their work?
- How does each organisation use these factors to influence *Dais*' work and promote income security?
- How do *Dais*' perceptions vary from those of others in terms of the value of their work?

The HFA and the *Ottawa Charter* frameworks were used to investigate the effect of their all-inclusive language on *Dais*' work and position in Gujarat and SEWA:

- How well have *Dais* been integrated in the overall primary health care system of Gujarat?
- What strategies have been used to bring about this integration?
- Does the type of human resource utilisation (appropriate and accessible) as specified by the WHO truly personify the situation of the *Dais* in Gujarat?
- What has been SEWA's approach with the *Dais* in the promotion of primary health care? Is the organisation's interpretation and implementation of strategies to promote primary health care similar to or different from that of the Gujarat government?

The RCH framework, however, was not fully implemented during my fieldwork.[125] The Gujarat government was still conducting educational programmes for health care workers and health officials to familiarise them with the change in focus for health. However, the NGO SEWA had already begun to implement some of the strategies outlined in the framework in its work to empower women and to teach men to share the responsibilities of women's health. One of the ways it has done so is to involve men in health work. Although the RCH was not fully implemented at the state level, I use the work of SEWA as an example to show the potential benefits to *Dais*, clients, and the health care system if the GOG implements the spirit of RCH.

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[125] It is not clear whether the RCH framework had been implemented in light of natural disaster in 2001 and the political and social upheavals in Gujarat in 2002.

- What are the steps that the government of Gujarat is taking to assist the *Dai*s in its move to implement the RCH?

In the next chapter I present the multiple realities of the *Dai*s and those around them to show how work and health intersect in their lives.

CHAPTER 7

FINDINGS: UNDERSTANDING *DAIS*' WORK THROUGH MULTIPLE PERCEPTIONS

Introduction

This chapter presents the multiple perceptions of *Dai*s and their work. These perceptions are drawn from the interviews and focus groups conducted during the fieldwork (Appendix I). Multiple perceptions are presented to provide a more integrated view of the *Dai*s' position from within the formal health system and from outside the system. Insiders' views have been obtained from health care workers and health officials. Those who are outside the system include village functionaries, *Dai*s' clients and families, and SEWA women. *Dai*s, however, remain the centre of these perspectives. *Dai*s find themselves in a unique position because they work within the formal health care system while they remain outside the system as informal health workers. It is their in-between state that is of interest in this study.

The first section of this chapter covers questions from pages two to four of the survey form (see Appendix F). The questions were developed to explore the various aspects of a *Dai*'s work. The questions include the advice she gives to women regarding contraceptives, referrals, access to transportation and safety, her relationships with biomedical personnel, remuneration and income, and her perceptions about her work. SEWA *Dai*s are asked additional questions regarding their membership in the *Dai* co-operative and the SEWA organisation.[126] In keeping with the goal of presenting multiple realities, I use quotations and vignettes, the voices of various individuals, to reveal their understandings of *Dai*s' work.

SEWA and Non-SEWA *Dai*s of the Urban Area

The urban *Dai*s in my sample included 14 non-SEWA and 13 SEWA *Dai*s. All were from Ahmedabad City and all were from lower castes. The majority of the *Dai*s live in slums, where basic amenities are usually absent. The *Dai*s in both groups are all currently practising;

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[126] These findings are consolidated with the findings from rural SEWA *Dai*s because similar themes have emerged.

hence they are referred to as *active Dais*. The *Dai*s usually begin their delivery work after giving birth to their children and when they are older. This is because *Dai*s are then free from their childrearing activities. Furthermore, women trust those who are older because they are perceived to be experienced and knowledgeable. For example, two SEWA *Dai*s were already married by the age of seven years[127] (the mean is 12.8 years). By the age of 15, they had experienced their first pregnancies. In the non-SEWA group, two *Dais* were married at the age of 12 years (the mean is 15.9 years). Both SEWA and non-SEWA *Dai*s learned their work from their mothers-in-law, grandmothers, mothers, sisters-in-law, other *Dai*s (not related to them), nurses, and private physicians. Two *Dai*s from each group said that they learned how to deliver after experiencing their own deliveries; no one taught them. For example, a non-SEWA *Dai* said that she learned from dreams and visions and from giving birth to four children *"by myself with no assistance"* (NSAhd3).[128] In the SEWA group the average age for beginning their apprenticeship was 24.45 years, and in the non-SEWA group it was 25.14 years.

The high average number of deliveries conducted by the non-SEWA *Dai*s or the low average by the SEWA *Dai*s may be due to a number of factors (Table 4). First, it may represent mistaken estimations on the part of the *Dai*s, because most of the *Dai*s do not keep statistics. I calculated averages from the estimations they shared with me. Both figures could be different if maintaining statistics were to be part of *Dai*s' work. Second, in the non-SEWA *Dai* sample, 6 of the 14 *Dai*s are Muslims. This point is significant. According to health care workers, Muslims do not believe in family planning, and therefore using contraceptives is usually not allowed. Those who use contraceptives do so in secrecy.[129] One FHW of Mehsana said:

> *The Mohammedan [Muslims] do not believe in family planning. It is against their religion, so they do not get operated [tubal ligation] but they undergo MTP [abortion] secretly. So we explain to them that this too is a sin and an operation would be better than an abortion. But they do not understand, so they continue. Some may agree to have an operation, but we have to be very careful. I have to lie and say that they are ill to maintain their confidentiality. In my village 50% of the population are Muslims. I cannot*

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[127] Although they are married at an early age, they do not go to their in-laws until they reach puberty.

[128] To ensure confidentiality, I identify SEWA and non-SEWA *Dai*s in Ahmedabad as *SAhd* and *NSAhd* and in Mehsana as *SMeh* and *NSMeh*, respectively. The numerical beside these identifiers indicate individual *Dais*. To avoid confusion, I will identify only *Dai*s whose answers differ from the rest.

[129] This observation was unanimous among all the health care workers whom I interviewed. They included six physicians, five FHSs, 15 FHWs, and one MPW. And although I am not including the data from my informal sessions with urban health care workers (three MOs, seven FHWs), they too made similar observations.

> *go with them [women] to the hospital. I go separately and keep a distance of at least 1 km. Similarly, I cannot accompany them back to their homes nor do any follow-up work. So the next day I have to be very careful and plan my visits in such a way that I do not give rise to any suspicions.* (FHWm2).

Table 4

Work Profile

Units	SEWA (n=13)	Non-SEWA (n=14)
Years of practice (average)	24.9	19.6
Age of commencing work as a *Dai* (average in years)	25.8	26.5
No. of deliveries conducted per year (average)	14	52[130]

Dais in both groups travel to other communities to conduct deliveries. For example, six SEWA *Dais* said that they travel between 2 and 10 km from their homes, and one *Dai* has travelled as far as 20 km to attend a birth (SAhd6). In the non-SEWA group, all *Dais* except two indicated that they had travelled distances ranging from 3 to 15 km to attend births. This information could have implications for the future planning of health services and health policies, especially in the context of RCH. First, if *Dais* are travelling such distances, then SEWA's stance that *Dais* be included in the RCH framework appears to be valid. *Dais* are contributing to the formal health care system. It also indicates that *Dais* are accessible to people outside their communities. Second, *Dais* continue to be utilised even though there are four major public hospitals in the city. Based on these observations, it seems that the future plan of phasing out *Dais* may not be a viable option. Despite the availability of health services, it appears that these centres do not meet the needs of the people, especially those who are in the lower income bracket. Affordability is a key issue when it comes to families of low income bracket. Unlike services procured in hospitals and clinics (government or private), where transactions are in cash, usually paid up front, *Dais* accept both in-kind and cash payment (see Table 7), depending on the family's ability to pay. The other reason could be the *Dai*'s reputation. One *Dai* (SAhd6) said that because she provides good service, women from other areas call her to attend their deliveries.

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[130] When I calculated this I removed the two extreme outliers to provide a more balanced average. These are 2 and 60 per year.

Advice on Family Planning and Contraceptives

*Dai*s of both groups provide information about contraceptives to clients (see Table 5). One SEWA *Dai* who did not attributed this to her shyness even with women (SAhd13). On the whole, advice on contraceptives is given only to women and not to men, although one non-SEWA *Dai* (NSAhd7) mentioned that she advises men to undergo vasectomies, and another non-SEWA *Dai* (NSAhd11) encourages individuals to abstain. However, she did not indicate whether the advice to abstain was directed to males or females. One SEWA *Dai* said that she knew of another method in which women could receive an injection to prevent conception for five years, but she did not remember the name of the injection (SAhd6). A Muslim *Dai* from the non-SEWA group felt that women could undergo medical termination of pregnancy (MTP), but men should not have vasectomies because they would lose their physical strength and forfeit their ability to pray for the rest of their lives (NSAhd9).

Table 5

Advice on Contraceptives and Family Planning (FP)[131]

	Yes	**No**	**Male condoms (Nirodh)**	**Tubal ligation**	**Birth control pills (Mala-D)**	**IUD (Copper T)**	**D &C**	**Other**
SEWA (n=13)	12	1	6	5	10	8	2	Injection (1)
Non-SEWA (n=14)	14	0	13	11	11	11	1 (MTP)	Abstinence (1) Vasectomy (1)

In giving advice to women, the *Dai*s are working on the assumption that the information will filter to men. *Dai*s do not approach men because of the barrier between men and women in South Asian culture regarding sexual matters. *Dai*s in both groups are able to provide the rationale for each type of contraceptive and its function. These range from having small families and the high cost of raising children to spacing to prevent multiple pregnancies and protecting women's health. The *Dai*s' ability to provide information for family planning and contraceptives is one of the objectives for training *Dai*s under India's *Health for All* (HFA). An FHW in Mehsana recounted how the knowledge of the *Dai*s eases her workload. She said:

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[131] The numbers in the columns add up to more than the total sample because each *Dai* gave multiple answers.

> *One benefit apart from the decrease of IMR and MMR is that previously there was no registry of birth and death. The register at the talati [revenue collector] office was always blank. After training the Dais, they began to register the deliveries they had conducted and also any deaths. Women are encouraged to get vaccinated. They are provided with family-planning information, and Dais motivate women who are potential candidates [for tubal ligation]. People listen to them, and these women have the respect of the community. For example, there was a young woman under my care who wanted to have a tubal ligation. But she said that she would wait for Manekbehn [a Dai] to return from Ahmedabad and then go with her for the operation. I asked her why. She said that "she [Manekbehn] was present and delivered all my five children, and I did not spend money, so I want her to come with me this time as well. I want her to benefit this time." So I told Manekbehn to bring the woman so that everyone can benefit. My caseload is lightened, the woman will have her operation, and Manekbehn*[132] *will receive her payment.* (FHWm1)

Ten SEWA and 12 non-SEWA *Dai*s stated that they had accompanied women to either the post-partum unit (PPU) or family planning units (FPUs). These units provide counselling for family planning, contraceptives, and vaccinations. At some of the units, dilatation and curettage (D&C) operations are performed, so *Dai*s accompany women to this procedure and back.

Dais' Access to Transportation and Safety Issues

Because *Dai*s travel long distances, access to vehicles and safety concerns are important issues (Table 6). *Dai*s of both groups said that it is usually the woman's family who arranges the transportation and comes to fetch them when the woman is ready to deliver. However, there are instances in which the *Dai*s' family members assist in providing the transportation. For example, the son of one non-SEWA *Dai* (NSAhd4) takes her on his scooter, and a son of a SEWA *Dai* (SAhd11) takes her on his bicycle. *Dai*s are unwilling to go if a male comes to call for them unless there is a woman accompanying him. They usually only go with a man if he is known to them or to the community, although again this varies amongst the *Dai*s. For example, eight

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[132] *Dais* are paid Rs. 30 per case when they motivate women to participate in family planning. The exchange rate was C$1 = Rs. 38 during my fieldwork (1999-2000).

SEWA *Dais* said that they felt safe at night, but only if someone accompanied them. Two SEWA *Dais*, on the other hand, felt unsafe at night. One related that she was assaulted at night while on her way to a delivery (SAhd13), and another *Dai* said she is afraid of being robbed because there is a high rate of alcoholism in the area where she lives (SAhd6).[133] In the non-SEWA group, four *Dais* felt that it was unsafe to travel at night. One *Dai* said, "*Nowadays times are bad. I am young, and that is why I do not go often. I only go with someone whom I know. Even if ladies come to call me, I go with them if they are known to me*" (NSAhd1). A *Dai* who was unafraid to go out at night said, "*I have faith in God because I am doing good work. I will go with a man if he is recognised by someone or mentions the name of a person whom we both know*" (SAhd8).

Table 6

Transportation

Transportation	**Autorickshaws**	**Bicycle**	**Scooter**	**Other**[134]
SEWA (n=13)	7	1	0	5
Non-SEWA (n=14)	13	0	1	1

Thus it seems that safety is a concern for all *Dais*, even those who are unafraid to go out at night. However, they have adapted a few strategies to address this concern and, in doing so, continue to make themselves available to women who need their services. They do so because *Dais* perceive their work as good work. But there is another reason for their accessibility. It is one avenue to supplement or earn an income. Their availability is also linked to economic necessity.

Dais' Remuneration and Impact on Their Families

Table 7 shows that *Dais* accept various kinds of payment ranging from in-kind to monetary. This is one way that *Dais* ease the financial burden of families. However, *Dais* reveal that families sometimes do not pay them even though they spend the entire night with the woman.

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[133] As noted, many of these women live in the slums, as do their clients.

[134] I placed the answers of the *Dais* who said that they walk to the place if it is nearby in the "other" category. So in reality, the figure for the autorickshaws could be higher. Again the numbers do not add up to the same number as the sample because a few *Dais* provided multiple answers, depending on where they were going to conduct the deliveries.

One non-SEWA *Dai* said that she had to ask the family for Rs. 11 "*because they are poor and so am I*" (NSAhd12). Although it appears that when *Dai*s receive some form of monetary payment, the amount is dependent on either the family's ability to pay or their willingness to do so. Many *Dai*s indicated that they do not like to ask the family directly for payment; they wait for the family to take the initiative. There are, however, exceptions to the rule. The testimonies of two *Dai*s in both groups reflect the experiences of other *Dai*s well:

> *What can we do if they do not give? There are no benefits. Who will give us any benefits? If people pay, then we have some benefits. If they do not, then we do not have any. They give Rs. 1000 to hospitals, and yet they give us Rs. 10. I did not even get Rs. 5 for an entire night's work.* (SAhd8)

> *In one case a doctor told the family that the woman needed an intravenous infusion, and the cost of the whole treatment [childbirth] would be Rs. 8000, but I did her delivery at home. The family only gave me Rs. 400. I asked for Rs. 500, and they refused me. They were willing to give the doctor Rs. 8000 but not the Rs. 500 that I asked.* (NSAhd13)

Table 7

Nature of Remuneration

Types of payment	**Money**	**Grains**	**Vessels**	**Cloth/clothes**	**Ornaments**[135]	**Other**[136]
SEWA (n=13)	13	11	2	8	0	9
Non-SEWA (n=14)	14	9	2	9	0	11

In the SEWA group, 10 *Dai*s said that they were not satisfied with their payment, two were satisfied, and one had no comment; in the non-SEWA category, nine *Dai*s were dissatisfied and five were content with their payment. However, those who were dissatisfied explained their unhappiness in the language of charity and helping poor families, and having no choice but to accept what they were paid. One SEWA *Dai* commented:

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[135] This refers to either gold or silver jewellery.

[136] These include *gur* (brown sugar made from sugar cane juice), incense, glass bangles, and coconut. *Dais* gave multiple answers.

> *I have to be [satisfied]. What can I do? Especially if it is a poor household, then I get a lot of blessings. I do not ask for money. If they give of their own free will, I take it. How can I ask for money from a poor household if they have only one meal a day?* (SAhd8)

The *Dai*s' relationship with the woman's family is a mixed one. On the one hand, the *Dai*s felt that their work is an act of service, and even if they are not paid, at least they receive respect and blessings. At the same time, they felt that their charitable nature is being taken advantage of because they are members of the same community.

The issue of gender bias further affects the amount and the type of payment. *Dai*s said that families usually paid them less if the child born was a female rather than a male. For example, seven SEWA *Dai*s reported a difference of between Rs. 15 and Rs. 30; whereas in the non-SEWA group, 14 (all) of the *Dai*s reported a difference of between Rs. 24 and 200. Two non-SEWA *Dai*s related the replies of families when they were asked why they paid them less for the amount of work they had done:

> *I ask them why they paid me so little. I say to them that "it is not my fault that you have a girl." I remind them that "if you had gone to the hospital or a private clinic, then you would have paid more." I spend about Rs. 25-50 to buy food and vegetables for my family. They [family] say that "if it had been a boy, then we would have given you Rs.500-600, but it is a girl, so it is a lifetime liability; we have to spend lakhs in future.* (NSAhd8)

> *They do not give much because the family said, "We have received a three-lakh bill [liability as in dowry]. If it had been a boy we would have given you more and a sari. Let us see what is our luck next time, and we will make you happy and give Rs. 501.* (NSAhd9)

The wide difference in the monetary payment between genders contrasts with the nature and amount of in-kind payment. The *Dai*s in both groups noted that in-kind payment was dependent on the economic status of the families and not related to the gender of the child.

On the whole, the income that *Dai*s earn from their delivery work is important in the running of their household and meeting the expenses. Nine SEWA *Dai*s and 11 non-SEWA *Dai*s said that income from delivery work is used to buy foodstuffs, clothes, and other household necessities. In addition, the money is used to supplement their income if the main income earner's employment is seasonal. But the *Dai*s also noted that because of the erratic nature of the payment, they also do not rely solely on this source of income. They do other work such as sewing quilts, massage, rope making, peeling garlic, selling indigenous medicines, running a sewing class, and rolling *bidi* (indigenous cigarette). Three *Dai*s (one SEWA and two non-SEWA), however, managed to meet the matrimonial costs of various family members from their *Dai* earnings. This SEWA *Dai*'s experience reflects the experiences of the other *Dai*s:

> *Yes, I even managed to marry off my children, my young sister-in-law, and even her daughter. They [people] pay obeisance to me. I receive a lot of blessings, and they respect and trust me more than they do a doctor, and offer me food and drink. Families invite me to their children's wedding if I delivered them and give me a sari or money.* (SAhd12)

*Dai*s in both groups would like to see changes in the way they are paid. At the present time, urban *Dai*s do not receive the Rs. 20 for each delivery to which rural *Dai*s are entitled. Urban *Dai*s are therefore dependent on the goodwill of the families. The desire for equitable remuneration was a common sentiment voiced by *Dai*s in both groups. These women want to be paid for the work they do the same way that physicians are paid for their efforts. *Dai*s know that they are able to help families defray the financial costs of institutional births. They want this important contribution to be recognised by the families and the municipal government in a fair and tangible way.

Dais' Suggestions to Families and Government for Change in Remuneration

Ten non-SEWA and 11 SEWA *Dai*s made suggestions on how families could improve their payment. SEWA *Dai*s suggested an increase in a range between Rs. 200 and 500 per delivery. The non-SEWA *Dai*s, on the other hand, suggested a range of between Rs. 500 and 700 per delivery, although one *Dai* said that Rs. 2000 per delivery was reasonable. They provided these figures based on their experience and knowledge of the amount that families pay for deliveries in private hospitals. A non-SEWA *Dai* made the following observation:

> *They [families] should think about it themselves. If they go to a private hospital, they pay at least Rs. 5000. They should pay at least Rs. 2000-3000 per delivery, especially when I do so much for them. Even in a private hospital it is the ayahbehn [housekeeper], and not the doctor, who conducts the deliveries. But people who come to Dais are of low socioeconomic status.* (NSAhd12)

Another non-SEWA *Dai* noted that delivery work affects her health, and the monetary remuneration that she receives does not compensate for the long-term effects on her health. She said:

> *I handle nine months of dirt and heat, faeces, urine, and it affects me so I wish they would increase the money.*[137] *At the private hospital they have to pay Rs. 4000, so they should at least pay me Rs. 500 per delivery. I have to clean all the dirty stuff and clean the place and wash their clothes.* (NSAhd14).

And yet the *Dai*s noted that despite their attempts to assist the families in saving money, they receive remarks from family members such as *"if we go to the Municipal hospital, it is free, so why should we pay you?"* (NSAhd12). *Dai*s said that even when clients go to a public hospital, their families still end up incurring costs of Rs. 1000-2000.[138]

Fourteen non-SEWA and 12 SEWA *Dai*s felt that government should implement a payment system so that their remuneration is equitable. *Dai*s in both groups said that this could be in the form of either a monthly salary of at least Rs. 1500-2000 or a minimum of Rs. 150 to 500 per delivery. Either way, *Dai*s observed that it would ensure that they have a steady and secure income and work. One SEWA *Dai* noted that regular income could be a financial buffer and social security for *Dai*s in their old age. She observed:

> *We should get at least Rs. 1500-2000 per month as regular salary and a pension as a security for old age to avoid being a burden to our children, because they may say that this old lady is not doing anything and think of me as a burden.* (SAhd7)

Unlike the economic and social buffers for people who are in formal employment, where labour laws safeguard their rights as workers, women such as the *Dai*s of the informal sector do not have these safety nets. It is obvious that at the present time, in the absence of regulations, *Dai*s' income is dependent on the goodwill of individuals. This means that *Dai*s are not guaranteed regular income or work. The *Dai*s in both groups (SEWA and non-SEWA) said that if they had a choice, they would not do delivery work. A non-SEWA *Dai* answered the following when I asked her if she perceived any benefits from being a *Dai*:

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[137] It is believed that conceptions and pregnancy enclose the "stale air/wind." When birth occurs, the stale air or wind of nine months affects the eyes. *Dai*s said that their weak eyesight is a result of being exposed constantly to this dirty wind/air.

[138] According to one of my key informants, apart from the costs of buying medications and other miscellany, sometimes families have to pay other health care workers in the hospital for services that are not factored into the formal payment.

> *No, I do not get any benefits from this. I want my daughter to study and be educated. It depends on her abilities and brains. If she wants to be a Dai, so be it. Otherwise she has to do housework. We get what we put out in terms of our effort. I consider it [Dais' work] beneficial only if I receive over and above what I put out in terms of money, vessels, cloths, grains, and so forth. I work as a Dai because of my children and for our stomachs. I am uneducated so I have to do this. Otherwise, if I were [educated], I would do something else.* (NSAhd8)

Another *Dai* gave the following views about her work:

> *How can I think this is good work? I do it out of necessity . . . for my stomach. I have no education, so there is no other work I can do. If I was educated like you behn, then I too, would fly in a balloon and see America.*[139] (SAhd6)

Dais' Knowledge of Referrals to Facilities

This question was to ascertain whether *Dai*s are knowledgeable about the medical facilities in their vicinity in the event that they have to refer women because of complications during delivery or pregnancy. During the interviews, health care workers and health officials attributed the high maternal mortality rate (MMR) and infant mortality rate (IMR) to *Dai*s' attempts to conduct risky deliveries instead of referring them to hospitals. They also felt that *Dai*s are unable to recognise signs and symptoms of at-risk deliveries. The data from the survey suggest that *Dai*s in both groups are aware of the facilities around them even though they may not remember the names of these places (this is more in the case of private institutions). The *Dai*s in both groups live near major public health facilities such as the Civil Hospital, VS Hospital, LG Hospital, and Sardabehn. Despite these major health institutions, two SEWA *Dai*s mentioned that medical assistance was inaccessible to them because of distance and transportation costs.[140] Aside from public health facilities, *Dai*s of both groups were aware of various charitable (Trust Hospitals), private institutions, and government employees working in their communities.

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[139] Although I would tell those who asked me that I was from Canada, many Gujaratis in Gujarat would equate this with America. This is because their relatives, friends, or someone's family member have gone to the US either to work or to live. Thus in my research it was common for people to equate overseas with America.

[140] Although there are pockets of slum areas within the city limits, there are other slums in the outlying areas. So even though the facilities are deemed accessible, in reality it may not be so.

Dais' Relationships With Health Care Personnel

The *Dai*s' treatment in the hands of various health personnel could be one of the reasons why they do not go with the woman to public hospitals or refer her to a private hospital or do not identify themselves as *Dai*s when they do go to public institutions. Both SEWA and non-SEWA *Dai*s had experienced lack of respect by the biomedical health personnel. Seven SEWA *Dai*s said that they did not feel respected when they took women to government hospitals, and three *Dai*s (apart from the seven) did not identify themselves when they took women to these hospitals. One SEWA *Dai* said, *"The staff at S Hospital do not allow me to enter. They scold the relatives and ask, "Why did you bring a Dai with you?"* (SAhd8). A non-SEWA *Dai* narrated her experience in this way:

> *When I took a woman to the hospital, the doctor said, "Why didn't you do the delivery at home? Why did you bring her here?" They did not allow me to enter. They took the woman in. The doctor scolded me, but I did not say anything. I felt helpless. So I just stood by and listened for the woman's sake and kept quiet. It is only when I am unable to manage the case [delivery] that I take the woman to the hospital.* (NSAhd6)

Similar experiences were found among non-SEWA women (nine *Dai*s). Four *Dai*s (apart from the nine), however, said that private practitioners do consult them when they refer women to the clinics. In part this could indicate a symbiotic relationship between *Dai*s and the private physicians. According to a non-SEWA *Dai* this is because *"private doctors have to earn money, so they speak well to me. I refer patients to them, and they pay me Rs. 100-150 per case"* (NSAhd6). However, this type of relationship may not be the norm between private practitioners and *Dai*s, as illustrated by one SEWA *Dai*'s experience:

> *A private doctor in my area does not want women to have deliveries at home, so she tells them that the child's presentation is not normal. She advises women to have their deliveries at her clinic. In this way she earns about Rs. 2000. But those who are poor, how can they afford this? I conduct their deliveries at home, and she [the doctor] becomes angry. She asks me why I conducted the delivery at home. I take whatever the family gives me, whether it is Rs. 10 or Rs. 100, depending on the family's income. I am not greedy, but I do need the money for my family expenses. But it is not my duty to exploit people.* (SAhd8)

Urban Dais' Perceptions of Their Work

One of the questions that I asked *Dai*s is whether they felt pressured to work as *Dai*s. Eight non-SEWA and nine SEWA *Dai*s mentioned economic pressure as the main reason to work as *Dai*s. Only two non-SEWA *Dai*s said that they are working as *Dai*s because it has been a family tradition (NSAhd4 and NSAhd9). *Dai*s' statements below, however, provide a deeper understanding of the reasons why women engage in this type of work when it is considered to be ritually unclean:

> *For our stomachs. [Otherwise] who wants to put their hands in a dirty area? My husband cannot work because of weak knees, and he cannot walk. My sons have left me, so my only source of income is from Dai's work.* (NSAhd6)

Other observations include, *"I have a stomach. And I need money to meet my household expenses"* (SAhd6) and *"I have to go [work as a Dai] because my family is poor. . . . Only if you work will you get food; otherwise there is no advantage"* (NSAhd11).

These statements seem to indicate that *Dai*s perceive their work as a necessity rather than a choice. The statements indicate that *Dai*s would not choose to do delivery work if they had other options and avenues available to them. A sense of ambivalence runs through their statements about performing *Dai*'s work. On the one hand, they need the income to meet their basic needs. On the other hand, the income generated from the work appears to be inadequate to meet these needs. Compounding this is the social stigma of pollution and untouchability that is connected to their work. One SEWA *Dai* related her experience:

> *I am a member of SEWA, and apart from getting money from SEWA or blessings from people, there are no benefits from working as a Dai. I have been subjected to untouchability. Some people say, "Do not go there, or here, or don't touch this or that, or don't touch the cloth" because I have handled the dirty things [placenta, cord, and amniotic fluid]. And for this I get Rs. 25, and so sometimes I feel sad, and so I say no to deliveries.* (SAhd8)

Despite the ritual pollution and economic need, *Dai*s say that they do experience the social and spiritual rewards attached to their work. They stated that it is because of these benefits that they work as *Dai*s. Another reason is a sense of duty and obligation to contribute to society because they have the knowledge of delivery work. *Dai*s, by linking spirituality to their work, perceive their actions and work to be blessed. *Dais* attribute their sense of well-being to their work. They said, *"I am able to separate two lives, and therefore my soul is in peace"* (SAhd1) and *"I am able to comfort the woman and she feels happy. So I feel happy and satisfied"* (NSAhd8). Other statements that illustrate this link are, *"This is God's work"* (SAhd2); *"It is good to help"* (SAhd5); and *"We will receive blessings, because we have given peace to the woman"* (NSAhd13). One non-SEWA *Dai* was clear that it was because of the spiritual nature of her work that she was able to conduct a delivery that had been deemed impossible by the biomedical world. She said:

> *Dais are able to do things that at times the health personnel are unable to do. There was a weak woman who needed a blood transfusion. The doctor said that she needed four pints of blood before the delivery could occur. During the night of Lord Krishna's birthday she began to experience labour pains at home, and at 6:00 a.m. she delivered a male child. I helped her, and then I applied an abdominal binder.* (NSAhd13)

A SEWA *Dai* (SMeh7) linked her polluting work with the Hindu deity, Vishnu:

> *As a Dai, I am considered untouchable because I have to touch the dirt of nine months. But how can it be dirty when Vishnu lives in there? God [Vishnu] sits in there [the cord], so how can I say it is dirty? How can I be repulsed? I am not repulsed by it, and I am not dirty. The Nag [cobra, snake],*[141] *the nine-headed Nag when he fans his head [hood] is in there [the placenta]. I am narrating all these to you because you asked [me]. Otherwise, I would not discuss this.*

The common deity that Hindu *Dais* evoke is *Mataji* (Mother Goddess). The coconuts that *Dais* receive after the delivery are offered to the Goddess because *Dais* believe that it is she who assists them in their work. One *Dai* said, *"I receive blessings from Mataji [Mother Goddess] and also get food. It is not I who does the deliveries, but it is through the hands of Mataji"* (SAhd6). Muslim *Dais*, on the other hand, said that it is the work of *Allah*, and it is *Allah* who guides their hands and ensures that mother and child are safe.

All *Dais* (SEWA and non-SEWA) stated that because of their work as birth attendants, community members respect and trust them. Respect and trust, they observed, enhance their standing in the community. However, a SEWA *Dai* (SAhd7) noted that her community respects her because they need her. She said, *"I do not feel there are any benefits in Dais' work. . . . When there is work [childbirth], people call me 'behn, behn'; but after that no one calls me for many years."* It appears that the interpretation for the reasons that lead to trust and respect differs among the *Dai*s. To this *Dai*, it seems that trust and respect are linked to her ability to meet the needs of the community rather than to her, as an individual. On the other hand, a SEWA *Dai* said that people in her area greet her respectfully and value her opinions (SAhd13).

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[141] In Hindu cosmology the cobra, just like the cow and the monkey, is revered. The cobra is often associated with Lord Shiva. In other cases, one can also see in various icons Vishnu reclining on the coiled body of the nine-headed cobra. Both Vishnu and Shiva together with Brahma make the Hindu Trinity.

Another common theme among both groups of the *Dai*s is a sense of duty and obligation. In their narratives *Dai*s often stated that because of their knowledge and skill, they have a duty to assist women in their childbirth. When they do so, *Dai*s' families receive blessings. Common statements include, *"Dais' work is charity. I am saving somebody's soul, so my family is happy"* (NSAhd5); *"I feel that I have an obligation because I have learned it [delivery work]"* (SAhd9); *"We must be truthful because we have this knowledge [duty to use the knowledge to help others]"* (SAhd10); and *"Because I am able to separate two lives from one and help the woman and her child, I am doing good work. My health is good because of this, and my family is blessed"* (SAhd6).

Adopting Biomedical Procedures and Terms

Five SEWA and eight non-SEWA *Dai*s indicated that they wanted to include some of the biomedical tools and practices in their work. The SEWA *Dai*s, for example, want SEWA to build a women's hospital where delivery can occur. They said that not only will the hospital provide women with a place for delivery, but it will also ensure that *Dai*s have regular income and steady work.

> *We want a SEWA Hospital so that we can earn a steady income. We need a room with beds for deliveries. We can charge the patients fees to pay the hospital rent and our fees. We should be allowed to issue birth certificates. If I have a regular job, then I can apply for government loans and start my own business.* (SAhd8)

> *SEWA should give us writing pads with our names or with SEWA's so that we can write the child's information or prescribe medications just like the doctors. We should be allowed to give medications for pain and write on notepads. Otherwise, people do not*

> *believe us or give us respect. We should get equipment to listen to the sound (stethoscope) like the doctor has and a case to carry.* (SAhd6)

One SEWA *Dai* from the group (five *Dais*) wanted aprons or uniforms, syringes, needles, suction pump, gloves, a BP (blood pressure) set, and a thermometer to check temperature, which she felt would assist her in her work (SAhd13).

Non-SEWA *Dai*s wanted to learn how to give injections, hang intravenous solutions, insert intrauterine devices (IUDs), and learn about diabetes and blood pressure monitoring. They felt that acquiring these skills would enhance their practice further. One non-SEWA *Dai*, a Muslim, said that women come to her for IUD insertions because they are embarrassed to go to a doctor. She felt that if she knew how to insert them, it would be helpful to women (NSAhd5). This same *Dai* said, *"I use the forceps to clamp the cord and the suction pump to get rid of the secretions. I would like to get a foetoscope"* (NSAhd5). Another *Dai* already knows how to landmark the site to give oxytocin injections to accelerate the contractions and hasten the birth (NSAhd6). The common biomedical terms used by non-SEWA *Dai*s are *Methargin*, *Soframycin*, *infection*, *Savlon*, *sonography,* and *oxygen.* Words that were commonly used by both groups of *Dai*s are *Caesarian*, *PV (per vagina)*,[142] *TT (tetanus toxoid)*, *folic acid*, *vitamins*, *Mala-D (birth control pills)*, *BP*, *injection*, *and curettage.* Just like the SEWA *Dai*s, non-SEWA women wanted a regular job such as in a hospital and a salary to alleviate their economic anxieties:

> *I hope that the government would consider giving Dais work in the hospital to conduct deliveries, assisting the doctors. In the hospital it is the ayahbehn that conducts the deliveries and not the doctors. Then we would receive a regular salary. . . . I also want some instruments from the government. We should also receive certificates, because people ask me if I have a license to register their children's births. If we have a certificate, then we can legitimise our work and existence. Only then will the AMC [Ahmedabad Municipal Corporation] issue birth certificates.* (NSAhd4)

However, this same non-SEWA *Dai* noted that with new knowledge comes increasing responsibility and liability. She said, *"Previously we depended on Allah, and so people did not blame the Dais, but now they do because we know more"* (NSAhd4). A non-SEWA *Dai* who earns her income as a personal nursing aide felt that women should have deliveries in the hospital and not at home, especially if the woman requires injection (NSAhd14).

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[142] *Dai*s of both rural and urban SEWA and non-SEWA groups perform this exam to check the cervix dilation.

SEWA and Non-SEWA *Dais* in the Rural Area

My data revealed many similarities between urban and rural *Dais*. Some of the similarities include concepts of pollution, the equation of their work with the spiritual, good/charity work, advice given for family planning, concern for personal safety, remuneration, and the ongoing anxiety of being poor. In the rural group there were 33 SEWA *Dais* and 35 non-SEWA, all were from lower castes and from the district of Mehsana. The SEWA *Dais* were from one *taluka* (Kadi),[143] and the non-SEWA *Dais* were from three different *talukas* (subdistricts—Kadi, Visnagar, and Vijapur; see Map 5). All *Dais* lived in villages and were active *Dais*. As in the urban sample, the women in the rural sample married at an early age. For example, in the non-SEWA group at least 10 women were married between the ages of 11 and 13 (the mean is 15.6 years), whereas in the SEWA group six women were married between the ages of 10 and 14 (the mean is 16.2 years). The average age at which SEWA women began their apprenticeship was 31.2 years, and in the non-SEWA group it was 29.2 years. Table 8 shows that rural *Dais* began their work later than urban *Dais*. One reason is that rural *Dais* become free from their child-rearing duties later than urban women. This is because many live in extended household, which entails caring for other children in addition to one's own. Another probable reason could be that in rural areas, the newly trained *Dai* does not begin her work, out of respect for the experienced *Dai*, until the latter discontinues her work. This tradition may not be practical in the urban areas, where extended ties or familiarity may be tenuous.

Unlike the urban *Dais*, the interview data of rural *Dais* show that they had conducted deliveries that are considered to be risky, such as breech or transverse presentations, twins, and triplets. In the non-SEWA group, 25 *Dais* had delivered babies who were breech, 10 assisted women who had twins, and 2 *Dais* had been involved in the delivery of triplets. One of the *Dais* who conducted the delivery of triplets said that the woman's labour pains began prematurely during her seventh month. One child was born at home, and the other two were delivered en route

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[143] I wanted to have the same number of non-SEWA *Dais* in my sample as the SEWA *Dais* in Mehsana. Because I was unable to access the same number of *Dais* in the former group in Kadi, I decided to interview non-SEWA *Dais* in other talukas.

Table 8

Work Profile

Units	SEWA (n=33)	Non-SEWA (n=35)
Years of practice (average)	27.8	21.8
Age of commencing work as a *Dai* (average in years)	36	30
No. of deliveries conducted per year (average)	16	24[144]

to the hospital. None of the babies survived. In the SEWA group 11 *Dai*s had assisted women whose babies were breech, and 18 *Dai*s had been involved in the delivery of twins. None of the *Dai*s mentioned delivering triplets. This phenomenon of *Dai*s attending to risky deliveries could be attributed to a number of reasons. It could be that in rural areas health care facilities are not as easily accessible to women as in urban areas, and therefore when labour begins, *Dai*s are called to the scene first. Related to accessibility is the issue of cost, which in some instances may pose a burden to the family. Because of this, they may be reluctant to go to hospitals, and call the *Dai* to attend the delivery.

One SEWA and three non-SEWA *Dai*s said that they had performed external cephalic manoeuvres in breech and transverse presentations. A non-SEWA *Dai* commented that if a woman experiences post-partum bleeding, then she advises her to sleep with her legs raised, and the *Dai* massages the abdomen so that the uterus will contract to stop the bleeding.

Only two non-SEWA *Dais* (rural) amongst all of the *Dais* (urban and rural) mentioned that they instruct women in labour to stand and hold the window frame or the pipe or the rope and to bear down during the contraction and push while closing their mouths (NSMeh12 and NDMeh33). *Dais* of both groups said that the umbilical cord should not be cut if the child does not cry or breathe, because the soul is still in the placenta. The cord should be cut only when the placenta is expelled and when there is no pulsation in the cord, indicating that life has entered the child. Only one non-SEWA *Dai* said that she advises women to rest, to avoid carrying heavy loads, and to sleep with her legs elevated if she suspects that the woman may experience premature labour or early engagement during her seventh month.

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[144] As in urban non-SEWA, I removed four extreme outliers to provide a more balanced average. These are between 2 and 3 per year to 15 and 20 deliveries per month. I would approximate the number of deliveries of *Dai*s who provided me with monthly figures.

Twenty-three non-SEWA and 20 SEWA *Dai*s mentioned applying *kallo* (fundal pressure) when assisting women during their deliveries even after they were told by health workers and trainers that this practice is considered harmful to the birthing women; however, it is interesting that *Dai*s denied applying fundal pressure when they listed what they had learned in their biomedical training. In regards to family-planning methods, rural *Dai*s provide similar advice and rationale to that of urban *Dai*s, and only to women, but not to men. Only one non-SEWA (NSMeh23) and four SEWA *Dai*s said that they do not give advice regarding family planning because women can access the information at any health clinic. One SEWA *Dai* said, *"It is not my religion to give advice"* (SMeh5), and another SEWA *Dai* attributed her reluctance to her illiteracy (SMeh6).

Rural *Dai*s are also concerned about their safety when they are called to deliveries in the middle of night. Like urban *Dai*s, they go with people whom they recognise, and it is the family of the woman who arranges the transportation if the delivery is in another village. However, the type of transportation is more varied in rural areas than in the urban. It includes farm tractors, jeeps, bullock and camel carts, autorickshaws, and *chakados*.[145] At least 12 non-SEWA *Dai*s said that they travel to other communities within a range of 1 to 7 km, although one *Dai* reported that she had travelled 20 km[146] (NSMeh23); in the SEWA group 10 women travel within a range of 2-3 km. During the monsoon season, travelling to other villages becomes difficult because many of the arterial roads from the main highway to the villages become impassable due to flood and mud.

Birth Abnormalities

The narratives of rural *Dai*s seem to indicate that abnormal births and deformities are more common among rural women than among urban women. Six non-SEWA *Dai*s reported delivering deformed babies, compared to three SEWA *Dai*s. These deformities were not described in medical terms but in common language that identified the babies as either animals or supernatural beings. For example, *Dai*s said that they have delivered babies that looked like a monkey or a pig or babies with two horns. One non-SEWA *Dai* said that she had delivered a *"baby who had two heads—an actual head and a swelling on top the head. The baby lived for five days"* (NSMeh30). Another *Dai* reported that she had delivered *"a baby who had a red depression at the back of his head which later turned black. The baby died a month later"* (NSMeh31). A SEWA *Dai* said that she had delivered

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[145] *Chakados* are motorised three-wheelers. The back is similar to the bullock cart and is attached to a motorcycle.

[146] Although the *Dai* did not say this, according to one of the key informants who has worked with *Dai*s extensively, it was a relative of the *Dai* who called her to attend the delivery.

> *a child with a hole in the back. It was dark red in colour, and I realised it was not right, and it was very soft. I handled it with a lot of care and took the child to the hospital. It only lived for two months.* (SMeh5)

The most dramatic account was given by a non-SEWA *Dai* who said that she had delivered a stillborn baby that looked like a ghost. According to this *Dai*, the spirit of the deceased baby harassed and threatened her with harm through her dreams. Apparently these ceased once the woman gave birth to her second child, who lived (NSMeh32).

Describing abnormal births and deformities in newborns, couched in everyday language, appears to be one way for *Dai*s and people to cope with the death. However, the description of these babies in this way makes it difficult to understand the cause of the deformities or abnormalities. Description of this type could lead to deaths not being recorded because it may be perceived as natural or fated, leading to inaccurate statistical data. Because their descriptions appear unusual, biomedical practitioners may not believe the *Dai*s' accounts.

Biomedical Training and Pressure to Work: Rural Dais' Perspectives

Apart from economic necessity that one SEWA *Dai* described as *"my misfortune as I do not have financial support or anyone to turn to"* (SMeh20),[147] three non-SEWA *Dai*s said that they are compelled to work as *Dai*s because of the biomedical training that they received. One of the *Dai*s reported that she took biomedical training on the advice of the *sarpanch* because there was no one else in the village to conduct the deliveries (NSMeh31); another *Dai* indicated that

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[147] Her husband is deceased, and none of her four children lived beyond 30 days. It is her first marriage, but the second for her husband.

"the nurse said that once you have taken training, you have to work as a Dai" (NSMeh18). A third *Dai* gave her reason as follows:

> *I am working as a Dai, but I am not satisfied [with the payment]. But if I do not work, they [health personnel] will ask after training, "Why are you not conducting deliveries?" so I continue to do the work. And second, I feel that this work is a work of charity, so I do it.* (NSMeh19)

However, the extent to which the biomedical training places an additional burden on women to work as *Dai*s is uncertain because women hide their unhappiness in language that portrays their actions as acts of charity and good work so that they do not appear as though they are dissatisfied or complaining to outsiders and their families. A SEWA *Dai* (SMeh19) perceived her biomedical training as a duty to provide service in her community: *"I do it willingly. Because I am trained, then what is the harm in providing services to all? It is a humane and a good thing to do"* (SMeh19). A second SEWA *Dai* explained the benefit of her training in the following way:

> *I like it very much because there will be some changes through the training. When our sons get married and the daughters-in-law come, then they too can learn from us. Eventually there will be changes in the family and the community. Then we will know how to maintain health, how to behave socially, how to keep our homes clean, and how to talk to people.* (SMeh7)

Although this SEWA *Dai* (SMeh7) perceived her training as advantageous, she observed that she had to conduct a difficult delivery on her own because the FHWn1 (health worker) refused to come:

> *The nursebehn [FHWn1] doesn't want to attend deliveries at night. She makes excuses. She says she is sick or unwell. For example, there was a delivery at 2:00 a.m. The woman was weak and had labour contractions, and I was called. I went to do the delivery. Her baby was stuck and she had fever and she felt weak. I asked someone to call the nurse. Her father answered and he said, "She cannot come at night because she is ill. She won't be able to come at this time." So I took God's name and did the delivery. I was able to release the child from the stomach [uterus]. The next day I asked the nurse why she did not come. She said, "If there is any problem and my body is sick, I cannot come." I said to her, "Why did you take the risk? If you are getting a salary of Rs. 7000, you should have kept more in touch, and you should have been more responsible.* ***We are common Dais; you are a nurse, like a doctor****. You should have come; you cannot say no." The*

> *nurse said, "I had a problem, some difficulty, and I was sick so I could not come." They [health care workers] talk like that.* (emphasis mine)

Apart from the above reasons, the common refrain of most rural *Dai*s is that they are working as indigenous midwives because they choose to and because their work fulfils the belief that doing good work (*poonya ka kaam*), such as assisting others, is a religious duty (*dharm*) for which they would receive blessings from people. Therefore comments such as "*of my own free will*" (NSMeh19); "*This is a service, and one gets God's blessing*" (SMeh12); "*a work of charity*" (SMeh22); and "*Separating one life into two is God's work*" (NSMeh35) were common from both groups.

Remuneration

One difference between rural and urban *Dai*s is payment. Urban *Dai*s do not receive the nominal Rs. 20 to which rural *Dai*s are entitled. The state government has mandated that rural *Dai*s receive Rs. 20 for each normal delivery they conduct and Rs. 50 for referring an at-risk pregnancy to hospital. However, due to logistical reasons such as funds being disbursed late either from state to district or from the district health office to the PHCs, *Dai*s are often not paid on time, if at all. Furthermore, there is confusion as to who should receive the payments. According to a senior state health official, HKGujAdd2, *Dai*s need not show their ID cards in order to receive the payments; however, health care workers at the village level say that this is one of the prerequisites to receiving payments. Other prerequisites include registering the name of the pregnant woman at the Primary Health Centres (PHCs), taking the woman for her prenatal check-ups, and ensuring that the *Dai* uses the *Dai Delivery Kit* (DDK) when conducting the delivery.

Generally, rural *Dai*s are pleased to receive some form of payment from the families (Table 9) and the government as recognition for their contributions. But *Dai*s from both groups indicated that the payment has given rise to certain misconceptions among community members. Because people assume the nominal fees that *Dai*s receive are salaries from the government, there have been instances when people refused to compensate *Dai*s for their work. One non-SEWA *Dai* revealed, "*Village people do not give us money, saying that "the government pays you." They say that they will give us payment if the government does not pay us the Rs. 20*" (NSMeh13).

Table 9

Nature of Remuneration for Rural *Dais*

Types of payment	Money	Grains	Vessels	Cloth/clothes	Ornaments	Other[148]
SEWA (n=33)	20	20	9	18	0	35
Non-SEWA (n=35)	30	20	3	15	0	23

Another non-SEWA *Dai* observed that people circumvent payment by creating and invoking kinship ties: *"Village people do not give us money. They say, 'You are just like our family member, so we cannot give you anything. We have to give the money to the doctor. We cannot pay you [money]'"* (NSMeh19).

Dais of both groups (SEWA and non-SEWA) felt that Rs. 20 is inadequate for the amount of work that they do and the time that they spend with the woman. For example, one non-SEWA *Dai* said that she is paid Rs. 50 for a day's labour on the farm and only Rs. 20 for the delivery, so she did not feel that there is any incentive to work as a *Dai* (NSMeh19). Similar to urban *Dai*s, rural *Dai*s suggested that the government should pay them either a monthly salary or a higher rate per delivery so that their household expenses are met, as well as to compensate for the loss of their earnings from other work. In the meantime, their household expenses are met from the earnings of other family members and *Dai*s' other work, mainly agricultural labour. Another similarity that rural *Dai*s have with urban *Dai*s is that they do not ask the family members to pay them, but wait for them to make the first move. Because of this, many *Dai*s do not get paid or are paid less. One SEWA *Dai* said, *"I do not prefer to ask for money. They should understand and give. To maintain my self-respect, I do not ask"* (SMeh24). However, a non-SEWA *Dai* observed, *"Whenever the nurse [FHW] attends deliveries, she charges heavily. Then why should I not charge? I ask the family to pay me"* (NSMeh15).

The *Dai*s find themselves in a unique position because even those around them within the community perceive their work as being infused with religious meanings. Words such as *dharm* and *poonya ka kaam* (work of blessing)[149] are applied to midwifery by the *Dai*s to cope with nonpayment by families, especially when some of them can afford to pay. The families of the delivering women, on the other hand, invoke the same sentiments, and although they are grateful and appreciative, they still avoid paying the *Dai*s. Citing religion and blessings from good work, *Dai*s and their families try to console themselves for the loss of income or exploitation. For example, a *Dai* in rural Mehsana noted:

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[148] These include brown sugar, incense, soap, and coconut.

[149] This term can also be translated as "blessings gained for the work."

> *If they go to the hospital, they would be charged Rs. 1000, but they [the family] give me only Rs. 100. I do not ask for money and take whatever they give. I want to save the lives of the woman and the child. God keeps me happy and healthy because I help save somebody's life, and I receive blessings. These are the benefits. The villagers respect me. When the family calls me to examine the woman, they will call the doctor only if I tell them to do so. This is how much respect people have for me.* (NSMeh19)

Another reason for the reluctance to be direct about fees is the fear of social repercussions in the community if the *Dai* is seen as greedy and selfish. The other reason for the reluctance is that many of the *Dai*s attend to births in poor families who are also living in poverty, as illustrated by the *Dai*'s comments below. Based on the notions of *dharm* and *poonya ka kaam,* this *Dai* felt reluctant to charge a fee to such a family. Even though she mentioned payment a number of times, she justified the family's nonpayment each time in terms of the blessings that she receives from helping the woman and her family. Because of this, she is performing good work.

> *I like my Dai work compared to other work. I prefer Dai work because a Dai's work is a* ***work of selfless duty. It is a reflection of my dharm. Whether you receive payment or not, it does not matter, so even when someone does not pay you, you do the delivery. So even if I don't get paid, at least I know her atma [soul] is satisfied, and she will praise and give me credit that I conducted the delivery well.*** *Her atma blesses me when I do the delivery well, and the woman's family saves at least 500-1000 rupees. It does not matter if she [the woman] does not pay me. The government is bound to pay me 20 rupees for the delivery, and so I get the money from the government. At least the woman can use the money to buy ghee and her family can have enough for food to eat. And if she needs medicine, say for diarrhoea or for colic pain, then she does not have to go out. Otherwise, she has to pay 400-500 rupees for rickshaw fare and extra for medication or for transfusion or this and that. You can spend lakhs. But if you give her common medicines and she gets it at home, then she will be all right.* (SMeh7; emphasis mine)

One *Dai* described the discrepancy in treatment:

> *Subhadrabehn, I work like a doctor. I give medicines like a doctor and do deliveries. I take the villagers to hospital because I am able to recognise the illness. I got the training from SEWA. I help in health camps. When I make my rounds in my village, the villagers call out to me as 'Doctor, Doctor.' They say that the doctor has come. So why is my work not regarded highly?* (SMeh8)

Similar to the situation of urban *Dai*s, there were some differences in the monetary payment based on the gender of the newborn, although the amount from Rs. 10 to 75 and the number of *Dais* (six SEWA and five non-SEWA) reporting appeared to be insignificant. Unlike the urban *Dai*s, however, the nominal fees from the government did not differ according to the gender of the child. It was the same for both of them.

SEWA Dai Co-operatives

The reasons for joining SEWA are similar in both the rural and urban groups. The reason why *Dai*s were not members of SEWA or the *Dai* co-operatives is that they did not know about the organisations. *Dai*s said that they became SEWA members first before going on to form the *Dai* co-operative. Women joined SEWA because they were encouraged by family members who were already SEWA members; they were motivated by SEWA workers and leaders through information sharing about SEWA work in various villages and urban areas; they were involved in various SEWA activities such as literacy classes, savings and credit schemes, and accessing health services during the various mobile clinics organised by SEWA; and they wanted to belong to a group for support and camaraderie.

The goal of the *Dai* co-operatives is to promote *Dai*s' health by increasing their social and political visibility, providing full employment and income, and moving towards self-reliance. *Dai*s noted that being part of a group would ensure that their demands were heard more than if they were alone. Mittal Shah made the following observations:

> *If we look at the entire SEWA structure, then where at all possible, we try to enhance the women's incomes and provide various opportunities such as skill upgrading and training. When this happens, then women themselves feel they are able to bring changes in their lives. So SEWA's focus is to ensure that women have secure income. . . . We saw that we could organise the Daibehns, [but] one of the main hurdles they face is that they lack visibility. SEWA recognises the contributions of the Dais. [However], it would be more*

> *helpful if the government recognised them because that would make a difference. Another reason [for the co-operatives] is that the income from the co-operatives could supplement whatever they receive for the deliveries from the government. And we want the government to give the Dais the funds to their co-operative so that they can control the payment.*

For self-employed women, the co-operative[150] is a tool by which, for the first time, they gain control over their work environment and income and determine production. The co-operatives further provide an avenue to bring women into the mainstream, where they can be partners in decision making as managers and entrepreneurs and have opportunities to enhance their skills (Lalitha Krishnaswamy).[151] Lalitha noted that despite SEWA's being the largest women's union in Gujarat, managing at least 84 co-operatives, SEWA is still not recognised by many of the male-dominated unions as a legitimate union. Lalitha observed that in a co-operative

> *women receive regular income, . . . and there is a collectivity that brings about uniformity in wages and income. Membership in a co-operative leads to women's visibility and increases self-esteem. All these things happen when people come together. As a grassroots organisation, we feel that a co-operative is a form of struggle, the same way as the union is. The changes in income and increased self-esteem are very important for the poor to manage their families and improve their quality of life.*

Thus, aside from the economic benefits, co-operatives are units that enable women to become empowered because they learn to speak up and know that people will hear them. Their empowered status leads to changes in their relations within their families and with outsiders and opportunities to meet individuals from other countries. According to Lalitha Krishnaswamy, poor women suffer from mental and physical fatigue. To her, the co-operatives are central to women's health because they provide an environment in which women can speak freely and share ideas. She related that, during a meeting of handcart pullers, the husbands of the women wanted to become members of the co-operative. When SEWA asked the women, they said no. They felt that they would not be able to speak freely if their husbands were around, and they would have to cover their faces. Thus to Lalitha and the women of SEWA, health is more than physical health. It is connected to

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[150] One of the best known SEWA Co-operatives is the SEWA Bank. Set up in 1974 in response to poor women's need for credit, it has become a worldwide model for an alternative method of banking to meet the needs of poor women within a mainstream structure.

[151] Lalitha Krishnaswamy (personal communication, April 1999) has been with SEWA since its inception. She is the vice-president of SEWA and oversees the various co-operatives.

> *being free to be a woman. . . . Better health also means freedom. And I don't mean only sexual freedom, but I mean freedom in terms of being able to talk, able to speak; and one of the ways that women have learned to speak is through leadership training they receive from the Federation.*[152]

Once they have high self-esteem, then they are able to gain control over their health and knowledge and become decision makers, thus increasing their political and social visibility and enhancing their economic level (Mirai; Lalitha; Mittal). The aim of co-operatives is to teach and to ensure that *Dai*s have the capability to manage their own business and decide how, when, and what services to offer.

In 1999 there were two independent *Dai* co-operatives and another in the process of being registered as a co-operative.[153] Based on the results of a study conducted in 1991 and the success of SEWA's initial mainstreaming strategy (Chapter 4), SEWA began work with the *Dai*s that eventually led to the establishment of two co-operatives (Kheda and Gandhinagar). The co-operatives strengthened the bargaining capacity of the *Dai*s and provided opportunities to learn and share ideas. Mirai outlined why SEWA embarked on organising the *Dai*s to establish the *Dai* co-operatives:

> *I think we were aware from the beginning that there was a high maternal mortality among our members, and those who could do something about it were the Dais. Also the Dais were the women of choice that members preferred to go to rather than the biomedical personnel because many poor women are treated insensitively*[154] *and poorly*

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[152] SEWA felt that it was imperative to form an apex body that would ensure that the concerns and issues of women in various co-operatives were heard at the state level; hence the formation of Gujarat State Mahila SEWA Co-operatives Federation. This federation then takes the concerns of the women to the national level, to the National Co-operative Union of India.

[153] These are Shri Krishna Dayan Co-operative Limited in Gandhinagar District and Shri Swashrayi Mahila Shramshakti Dayan Co-operative Limited in Kheda District, and currently under consideration is Shri Swashrayi Mahila Shramlaxmi Dayan Co-operative in Mehsana. The *Dai*s in Ahmedabad City and District come under the Health Co-operative Shri Swashrayi Mahila Lok Swasthya Co-operative Limited.

[154] Although not all biomedical staff treat poor women and their families insensitively, my brief observations concur with Mirai's. For example, I observed the following in a labour ward of one urban public hospital. A junior male doctor threatened to slap a poor woman when she cried in pain when he removed the cotton bolster from her cervix, placed there to halt the bleeding after a traumatic delivery. He did not tell her what he was going to do, nor did he ask her permission before removing the bolster. I was standing there when this happened. On another occasion a woman was threatened by a female trainee gynaecologist/obstetrician and a staff nurse not to continue moaning and to

> *by the hospital system. So their first choice was, and still is, the Dais. So, obviously, the Dais should be the focus if one wanted to do anything. The Dais are poor, working-class women, many of whom are destitute, lower caste Harijans.*[155] *They provide life-saving services, and these are the kind of groups SEWA Union focuses on. And, frankly, we were quite challenged by the idea that the midwifery could be a form of self-employment for some of the poorest women at the village level. It may not be full employment, but it sure could be a major support to these very, very poor, destitute widows and other women.*

Mirai noted that the co-operatives are another way of decentralising health care. Decentralisation of health care both in geographical distance and skill would build *Dai*s' capacities, enhancing their income level and social status. As members of *Dai* co-operatives, *Dai*s have social support from other women; and as a group, *Dai*s can initiate changes where results are attainable and visible (Mittal Shah). The experience of one Harijan SEWA *Dai* shows that she was able to overcome caste barriers to enter otherwise forbidden social arenas. Her skills and the confidence gained in being part of a larger group enabled her to temporarily create an equitable social relationship:

> *In my village there is a Patel woman whose three to four children did not survive. I spoke to her when she was pregnant again, and I asked her the reasons why her children did not live. Why had none of her deliveries been successful? She said, "How would I know? I give birth, and then they die." So I said to her, "If you do not observe untouchability between us, then I will come when you call me; but if you do, then I shall not come." So the woman said that she would not practice untouchability between us. When she called me I went and delivered her baby, and her baby lived.* (SMeh7)

This same *Dai* said:

> *Before I couldn't even speak or speak well; I did not leave the corners of my house. In the past leaving the house was uncomfortable. But now I even go to Bodeli alone and have been to Bhuj, Kutch. Before I would not leave the house; times were such that we would not be allowed to go out. But now after joining SEWA, I have gained the strength to speak freely. I can go to a taluka or a district and speak to a higher ranked officer. Previously, I felt that I did not have the wisdom to speak or say anything. Now I have become jagrut [literally, awakened, aware].* (SMeh7)

'cooperate with them' during the stitching of the cervical tear she had after an especially traumatic delivery. She was told that if she did not stay in the 'proper position' during the stitching, she would be taken to the operating theatre and would experience further pain.

[155] Mahatma Gandhi coined this word to replace the label *Untouchables*. *Harijan* means 'Children of God.'

A SEWA *Dai* of urban Ahmedabad gave her reasons for joining the co-operative as *"I am able to earn profits and have work. The group gets benefits, then I get the benefit from learning"* (SAhd12). Her reasons echo those of other *Dai*s, which again reinforce the need for stable employment, income, and health. On the other hand, being a member of the co-operative and of SEWA shows a shift in their power relationship either within their families or in the larger economic and social structures. Although more work needs to be done in terms of capacity building, some *Dai*s are beginning to experience the benefits of being part of the co-operatives. One *Dai,* who is also a SEWA community health worker (CHW), noted the following shift in her relationship with her family and the way that her community behaves based on that shift:

> *I make all decisions myself. They [the family] never interfere with my decisions. They let me do my work, and they do not stop me. My husband sometimes asks me to take care of the family first before I go to a delivery. I don't give the money to them [the family]. I keep the keys and the money. I have done all the important work, and it is my responsibility to arrange my daughter's engagement and marriage. My husband does not do this work. He had the habit of drinking liquor and spending money. So I started to manage the family myself. . . . When you go in the village and ask people where I am, they will be able to tell you. People call my son "[SMeh8's son]" and my daughter "[SMeh8's daughter]." People don't call them "[Cbhai's—her husband's]" son or daughter. I am very happy, and I make all the decisions regarding my family.* (SMeh8)

Another SEWA *Dai* in rural Mehsana summed up the benefits of joining the co-operatives well:

> *I have contributed Rs. 101 to buy a share and become a member of the co-operative. If a woman needs money, then she can receive a loan from the co-operative. And members are able to receive dividends like Rs. 1000, Rs. 500, or Rs. 100 after a year; and so these are advantages for the women. So what can this mandli [co-operative] not do? It [the co-operative] is to strengthen the Dais' grouping and enable us to move forward. It is also a social club where we can meet and share our stories. As the co-operative becomes strong, we will be able to get on our feet, and in future if we want to do other work, we will be able to do it.* (SMeh33)

Observations such as the following further provide a greater insight into the *Dai*s' motivation for joining a co-operative: *"I joined the co-operative in the hope of earning a regular salary"*(SMeh9); "*the opportunity to learn new things and move forward"* (SMeh14); *"to improve our lives and in the hope of getting a job by being a member of a co-operative"* (SAhd1). Other statements include, *"I joined the co-operative so that my daughters will have a future and* *income and dividends"* (SAhd12); *" It is like a club where we can meet and share"* (SMeh27); and "*I am able to buy cheap medications and health insurance"* (SAhd9).

Although the co-operatives are meant to enhance the *Dai*s' earning capacity (they are supposed to charge at least Rs. 101 for each delivery), *Dai*s are reluctant to do so for reasons discussed above. Furthermore, there were some concerns among SEWA health leaders that mainstreaming the *Dai*s could lead to the erosion of the original objective of valuing their indigenous knowledge, but Mirai felt that the co-operatives would provide the framework to ensure that this does not happen:

> *Well, it could be [erosion of indigenous knowledge], but we try to ensure that this does not happen. The main reason that we have managed so far is that they [the Dais] have their own organisations to fall back on, their own support group. So if someone treats them disrespectfully, they discuss amongst themselves and then take the individual to task. The Dais are able to hold their own because they feel they are not alone. Being members of co-operatives, they have become more empowered and more assertive.*

The benefits accrued to the *Dai*s from their memberships in co-operatives should be understood with SEWA's other initiatives such as *Dai* School and the issuance of the identity cards (ID). These initiatives are discussed in the section, which deals with SEWA's perceptions of *Dai*s' work. Mirai articulated the long-term goal of SEWA with respect to the *Dai* co-operatives and the *Dai*s:

> *We want Dais to be organised, and we want midwifery to be a form of a self-employment, through their own organisation. We would like the Dais to take up health actions beyond midwifery, which we think they are capable of. They have proved it. So the vision is slowly, slowly they become the barefoot doctors of their villages and expert in their own crafts. We want them to get the best information and technological skills in midwifery and health. We feel that that they should be central to all the government policies since women and children are the vulnerable segments of the population as they are the sickest and the poorest. Hence, the Dais have to be central to the process, so that is the direction we are moving towards.*

Perceptions of Health Care Professionals About *Dais*' Work

I present the perceptions of health care professionals in the beginning of this section because they come into contact with *Dais* daily.[156] These health workers provide health services at the village level. They are the link between the villagers and the higher health structure and officials. The health records that these workers maintain provide the trend of communities' health status and are the basis for further health planning. Each FHS/MPW covers between three and five villages with a total population of between 5,000 and 7,500[157] and carry out various primary health programmes in addition to other new health initiatives that are passed down by the state government (through the Government of India). Over and over again health care workers indicated that their workload has increased and that they find it difficult to carry out their work to their satisfaction. FHSn[158] explained:

> *Our workload has increased a lot. This has made it difficult for us to handle other aspects of our work such as deliveries. For example, in addition to our routine work such as family planning, malaria monitoring, the TB-DOTS programme, and other primary health diseases, we have to deal with various campaigns such as the School Children check-ups, the Pulse Polio Programme, and the recent Leprosy Eradication Campaign and new policies [RCH]. Our work and responsibilities have piled up and we feel burdened, and because of that we cannot render our services well.*

MOa, who had been practicing for 26 years in the rural areas, observed:

> *In the present multipurpose health set-up, each staff has to perform all types of work while neither the skill level of the worker has been upgraded nor the educational level adjusted. There are now so many programmes. They come one after the other. One programme is not completed when another one begins and so on. The staff becomes stressed and confused as to which job to do and how to be able to do justice to a particular task. For example, we have to decide whether to do delivery or to attend health camps or to do immunisation or to dispense the TB medications. There are so*

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[156] As noted in my data analysis, the information presented here is based on emerging patterns. In all the transcripts of the health care workers, patterns emerged based on similarities, corroboration, and co-occurrence. But this did not exclude statements that did not fall into any of these categories.

[157] The ideal is one subcentre for a population of 5,000. Sometimes he/she assumes the charge of additional villages if the position of the FHW/MPW at a particular subcentre is vacant. Each PHC covers a population of 28,000-35,314, with five to eight subcentres. None of the PHCs is fully staffed, and certain staff members rotate on a daily basis from one PHC to another.

[158] I have used this code to differentiate various health workers. Because each Primary Health Centre has more than one FHW, I use numerics to differentiate them.

> *many, and we are unable to do justice to them all. I feel that there should be specific staff for specific work so that the work gets done well.*

FHWn1 noted:

> *We have to do a lot of writing and keep weekly reports of all health work, in addition to our multiple programmes and fieldwork. Where are we going to find the time? We just write, write, and write. For example, in one village where I work, during one of the rounds of the Pulse Polio vaccinations I had to administer oral polio drops to 425 children in three days. So even if we do not like some of the government policies, what can we do? We have to follow them.*

It is within this context that *Dai*s' contributions to health work are welcomed. All the MOs, FHWs, FHSs, and MPW said that *Dai*s are key individuals in health care and link them with the villagers. They say that *Dai*s assist them to update their records on births and deaths, on women who require prenatal and postnatal follow-up, and on family-planning counselling. *Dai*s inform them of individuals (children and adults) who have been ill and require treatment. The observation of FHWm1 provides a common example of how the *Dai*'s interventions impact her work:

> *Because she [the Dai] helps me with my health work, she takes half of my workload. She helps me with the registration of births and deaths, informs me of the number of prenatal cases, and visits with me to check the postnatal cases. And if there are any problems in the village, she tells me so my work goes smoothly. So why should I not like her?*

*Dai*s assist in various vaccination programmes and campaigns such as the countrywide Pulse Polio to eradicate the disease. FHWm2 said:

> *For monthly vaccinations and the Pulse Polio programme I get the help of the Kantabehn [Dai]. I ask her to bring all the children. She registers all the deliveries that she has performed and gives me details of the progress of other pregnant women.*

Her experience was corroborated by all of the six MOs whom I interviewed. One of them explained:

> *They help the nurses. Be it immunisations or any other programmes like childhood or prenatal cases or campaigns such as the Pulse Polio campaign, they help our nurses. . . . And because they perform deliveries, the workload on our workers is lessened, and they*

> *are paid Rs. 20 per delivery. As long as they do good work, the Dais will always be around.* (MOm)

In regards to delivery work, all except two (FHWn1 and MOm) said that *Dai*s conduct deliveries according to the procedures they are taught during the training. *Dai*s follow the Five-Cs concept—clean hands, clean place, clean birth, clean cut, and clean cord—so that the risk of infection is reduced. FHSn noted the changes: *"Previously Dais used a sickle; now they do not. They applied fundal pressure; now they do not. So another change. And previously they conducted deliveries in an unclean area, and now they choose a clean place."* Although the observation of this FHS may be accurate in many cases (see section on rural *Dai*s), these women do perform fundal pressure during delivery. In addition, one rural non-SEWA *Dai* related an incident in which a woman developed labour pains while working on the farm and delivered in the field. This *Dai* had no choice but to use the sickle to cut the cord and a strip of her sari to tie the cord. MOm noted that *Dai*s are ignorant and tend to forget what they are taught. Therefore they have to be given frequent refreshers. FHWn1, who did not think that *Dai*s practiced the 5-Cs or followed the guidelines regarding safe deliveries, said that *Dai*s are greedy for money, and this greed motivates them to attempt at-risk deliveries. This FHW and MOm noted that despite *Dai*s being taught new techniques, many of them continue to practise their old ways, which are harmful. In her experience, *Dais* are unwilling to learn new skills. FHWn1 described the work and the attitude of the trained *Dai*s in this way:

> *I tell you bluntly that I do not like trained Dais, because no matter how much training you give them, they still mismanage the deliveries. They do not adopt any of the methods we teach, so I do not like them. We have given them DDKs to use, given them training, and told them to use gloves, but they still do not. If the case is complicated I tell them to refer them, but out of greed they do not refer. If I am around, then there is no question; but in my absence things like these happen, and so I do not like it.*

Her view was supported by FHWj and by FHSj and FHSa, who commented that there are times when *Dai*s do conduct at-risk deliveries. One reason for this, according to FHSa, is that the delivery starts out as normal but suddenly turns out to be risky, so the *Dai* has no choice but to conduct the delivery. FHWj said that *Dai*s revert back to their old ways when they are in a hurry, especially during emergencies, but she said that this is not a common occurrence nowadays.[159] FHSn, who indicated that *Dai*s do not engage in harmful practices, explained the *Dai*s' involvement in at-risk deliveries as follows:

> *If we find out that the delivery was actually risky but it had been registered as normal, then we should ask ourselves, Why do we want to create a bad impression of the Dai and of ourselves? We have corrected the mistake on the second day.*

That *Dai*s do conduct deliveries of twins, triplets, and breech presentation, deemed risky by the health officials, is illustrated in rural *Dais*' testimonies. However, FHWn1 also noted that there are cases where people refuse to go to hospitals for deliveries. She noted that *Vaghris* (one group of tribal people in Gujarat) usually do not like institutional births even when there might be potential risks. They prefer that the deliveries be conducted at home.

All health workers except FHWn1 were unanimous about the *Dai*s' social position in the villages. They said that because they are trusted and respected by the villagers, they are in a unique position to spread health messages. In most instances, they noted, people would believe them because they are residents of the same community. Therefore observations such as the following are common: *"People speak well of her. She is a good worker, and people believe what she says"* (FHWm1); and

> *She is from the village . . . and an elder and is respected by people because she has been around long enough and conducted many deliveries. . . . She is revered as a demi-god. Because of her constant presence, people trust her more than they do us. We only come once a week, and we are outsiders.* (FHWm2)

FHWn2, however, related that she and the *Dai* use the trust relationship between the *Dai* and the villagers to coerce women to accept prenatal care. She said:

> *We co-operate with one another. For example, if there is an expectant mother and she refuses to get vaccines, then the Dai and I threaten her. We tell her that during her labour none of us will come to attend her delivery. This works. Out of fear the woman comes and gets immunised. We instil fear in them so that our work gets done.*

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[159] Some of these are already listed by FHSn. Other old practices enumerated by these health workers include lying on the ground without any clean sheet underneath the woman or lying on a dirty quilt, unclean hands, applying *ghee*, cutting the cord with a knife, and tying the cord with unclean strings or threads.

FHWn1 said that she is not against *Dai*s, but she observed that because they are incapable of learning new techniques, the public does not have high regard for them. FHWn1 indicated that *Dai*s were not helpful and were incompetent, and she worries constantly in the event that *Dai*s mismanage the deliveries. She reported that a *Dai* had conducted a delivery, but left a piece of placental tissue in the uterus. The *Dai*, according to her, warned family members not to inform FHWn1 that she had conducted the delivery. FHWn1 came to know about it when the mother-in-law called her because the woman was in a lot of pain. But it seems that FHWn1 did not perceive all *Dai*s as incompetent. She regarded one *Dai* in her village as skilful. According to the FHWn1, this *Dai* is able to ascertain the baby's position, predicts the delivery time, performs PV examinations, boils the instruments, and wears gloves during the delivery.

Caste barriers and untouchability do not seem to be an issue in health care. Except for three individuals (FHSj, FHWa1, and MOm), the rest of the health workers, including FHWn1, said that there were no caste barriers that affected their work or the work of the *Dai*s. For example, MPWe said, "*When I joined in 1965, untouchability and caste barriers were present, but now these kinds of thing are not there.*" However, FHSj said:

> *If the water has to be chlorinated and the worker is not allowed [because of caste], then they have to ask someone else because the worker is not allowed to touch or go near the tank. If the FHW of one caste has to teach a male of a different caste, then this is also difficult. There are a lot of difficulties in our work. When we do surveys or immunisations, people do not come because the nurse has to touch them. If the health worker is a Harijan, she is not allowed to enter the house of the Vaishnav. If there is a delivery at a high caste home, then she is not allowed to touch any of the utensils, and it causes a lot of problem. . . . So people have to lie and say that I am not a Harijan.*

While FHSj discussed how caste affects health work, another, FHWa1, was uncomfortable in the environment in which she lived:

> *In the beginning I did not like it here. I was not comfortable and I was worried. I felt that, being a Rajput woman, how can I live in a Harijan village? So in the beginning I was unhappy. And there were drunkards and gamblers, and I was fearful for my safety. I went to the sarpanch and told him that I cannot live here and work in this village.*

However, this FHW felt that because of her caste, she now receives more respect from the people. She went on to say, "*Now they feel that in their village there is a high caste daughter [FHWa1],* *and they respect me more. They speak to me respectfully and touch my feet to apologise for their mistakes."*

There was complete agreement among these health workers, including FHWn1, about the level of payment to *Dai*s by the government. They felt that *Dai*s should be paid more than the Rs. 20 they are receiving from the government. FHSn noted that because *Dai*s are doing work which is considered to be risky, they should be better compensated by the government. Some of the suggestions as to how *Dai*s could be paid ranged from a monthly salary (amount unknown) to a per-delivery rate between Rs. 50 and Rs. 100. In addition, FHWm1 said that the government saves money when deliveries are conducted at home by *Dai*s, which offsets the strain on the health care system. The MPW felt that *Dai*s should continue to receive other benefits such as regular updating of their knowledge and skills so that *"Dais will benefit financially, . . . her knowledge, work contacts, and social prestige."* FHWm2 explained how *Dai*s' remuneration should be increased:

> *The government should provide more opportunities to the Dais and offer wages. For example, I am paid Rs. 6000 and do not conduct as many deliveries as Dais. Dais may ask, "Why is she getting this amount? She is not conducting as many deliveries as we are." So they should get a salary.*

FHWm2 provided another suggestion to ensure *Dai*s' economic security in their old age:

> *There should be a pension plan for the Dais according to their years of service. This is especially important for those Dais who are unable to work due to their age. Her income has decreased, and so she can use the income from the pension plan to help her. This is important in instances where her family may reject her, and so at least she will have an income.*

I was interested to know what these health care providers thought about the future of *Dai*s in Gujarat. Here the views were divided. Three FHSs, 12 FHWs, six MOs, and one MPW said that *Dai*s will continue to be present in the future and gave the following rationale for their answers:

> *Dais will remain. As of now we need one FHW for a population of 2,000. For a population of 5-6,000, one FHW is not enough, so the Dais will be needed. Generally, we cover three villages, and it is difficult to meet everybody's needs, and so the need of the Dais will be there. Also there will be deliveries in every village. I can attend the birth in*

> *the village I am in, but in the other villages if the deliveries occur, I cannot get there, so definitely the Dais will be needed.* (FHWn2)

> *The government should encourage Dais' work. Dais are helpful. They assist us without any remuneration. No one will provide so much service without any payment. They help us in every village where our staff are unable to go.* (MOa)

> *Dais will continue because they are of the village. It does not matter even if you increase the staffing of the health centres.* (FHSn)

Those who said that the number of *Dai*s will decline provided the following reasons:

> *As people become educated, there will be a shift of birth from the homes to hospital. The number of Dais will decrease when FHWs begin to stay at the subcentres, and it is only when there are no FHWs that the public has no choice but to access the Dais.* (FHWn1)

> *Nowadays the public places only half as much importance on the Dais' work as they did in the past. There are many private clinics and hospitals in almost all villages. The doctors give injections to hasten the delivery, whereas the Dais continue to perform fundal pressure to push. So the future is uncertain for Dais.* (FHSd)

Summary of the Health Workers' Perceptions of Dais' Work

The health care workers in the rural areas consider *Dai*s' contributions valuable.[160] They indicated that their workload is reduced when the *Dai*s participate in various health campaigns and manage the delivery cases in their absence. Although the overall findings show that the relationship between these health members and *Dai*s is cordial, based on mutual need, the dissenting voice of one, FHWn1 (and another noted in Chapter 6), could be an indication that this may not be so in reality. Although all health members except three said that caste barriers did not exist, the experiences of three workers told a different story. Whether caste barriers are present, and to what extent, may depend on the individuals. This issue needs to be further explored over a longer period of time. Caste is a sensitive issue, and when contextualised within the South Asian worldview of "saving face," telling a stranger about something which is perceived to be undesirable is not the thing to do. However, this is not to say that these individuals' information does not reflect the reality at the present time. It could be that caste barriers are indeed not present, or at least not to the same degree as in the past.

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[160] Health care workers in urban areas made similar observations about *Dais*' helpfulness.

The issue of *Dai* remuneration appears to be a recurring theme even among the health care workers. There seems to be an agreement that the Rs. 20 that *Dai*s receive per delivery is inadequate. Whether this level of payment will change is uncertain for now. This will depend on whether *Dai*s continue to be present and to what extent their contributions will be needed to meet the increasing demands placed on the health care system. I end this summary with a quotation from FHWm2, who gave another reason why *Dai*s will continue to be needed in future:

> *Dais do not think about education. They think that I am a Dai, I work as a Dai, and so my daughter or daughter-in-law will be a Dai. They do not think that our children should go to school and get an education. They do not send their daughters to school. So whatever tradition the children are born in, it will continue with them. The tradition [of the Dai] will continue, but they will not move forward. So Dais will continue.*

Perceptions of the Village Functionaries and Clients of *Dai*s' Work

I interviewed village functionaries and *Dai*s' clients because they are the residents of the communities where *Dai*s live and work. Because it was impossible to interview the entire village, these individuals provided a snapshot view of *Dai*s' work and contributions in their respective villages. There are both male and female participants in this sample. Unlike health care workers, where gender in some way is 'removed' by virtue of their work, here views pertaining to delivery and birth are mostly from women. In my sample, the *sarpanch*, *talati*, and water bore operators were all males (except one *sarpanch*, and she was also a *Dai*). This is because men usually hold these jobs. Only in Village A were the deputy *sarpanch* and *sarpanch* females. This does not include the *sarpanch*, whose husband appeared to make the decisions (see above, Chapter 6). I interviewed 12 women who were *Dai*s' clients. But I selected four[161] of 12 women because the four represented the educational range, reproductive history, socioeconomic level, and caste delineation of other women. They also provided both common and divergent views of *Dai*s and their work.

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[161] The ages of these women range from 25-26 years, and their education ranges from standard 5-9. Their obstetrical histories are as follows: (a) Sbehn—four pregnancies, one of which is a set of twins (three children are living; one female child died at age two months from congenital heart disease, and she underwent MTP [medical termination of pregnancy] with her third pregnancy, another female child); (b) Bbehn—five pregnancies (two children are living, two pregnancies ended in miscarriages, and a son was born prematurely at seven months and did not survive); (c) Vbehn—three pregnancies (two children are living, and she is currently five months pregnant with her third child; uneventful history); and (d) Jbehn—five pregnancies (three children are living; one pregnancy ended in a

The views of women and village functionaries were similar to health workers' perceptions of *Dai*s' role and contributions in their villages. The common view among all these individuals was that *Dai*s are available at all times. They leave their work and attend to women when called. However, a member of the *Mahila Mandal* gave a different reason for *Dai*s' leaving their work to attend deliveries. She observed that there is a territorial delineation amongst *Dai*s. This means that a *Dai* from Village V would not allow another *Dai* to enter her work jurisdiction because it would lead to a loss of face, decrease in prestige, and a devaluation of her skills (MMbehn). This leader noted that there is an unspoken agreement among *Dai*s that each *Dai* is solely responsible for the well-being of the clients in her area, and no one else should interfere.[162]

A *Dai* is supportive and kind and counsels women when they are afraid. Observations from clients such as, *"She is a good Dai; she gives good advice"* (Vbehn), and *"She is kind and good-natured. She consoled me when I was frightened and called me 'beta, beta'"*[163] (Jbehn) are common. According to the clients and all the women participants, *Dais* are experienced, skilful, kind, and good-natured. They are respected and trusted by people. However, all four clients said that their trust of the *Dais* was based on the fact that none of the deliveries in the past had resulted in death. None of the clients had asked the *Dais* whether they had received any formal training. To them, what mattered most was that she was kind and considerate and knew what she was doing. These are some of their comments: *"She is an elder and I am younger. Our relationship is like mother-daughter, so I feel shy to ask her if she is trained"* (Jbehn).

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miscarriage; and her second child was premature, born at eight months, and survived for two to three days). Jbehn is prone to premature labour, so she had cervical rings put in place for the first two pregnancies. These pregnancies went to full-term, but she did not do this with her last pregnancy. However, this child was full-term and is living. The average gap between pregnancies amongst these women is 1.5 years. I interviewed them in 1999, in rural Mehsana. Non-SEWA *Dais*' clients: Sbehn and Jbehn; SEWA: Bbehn and Vbehn. My small sample is similar to the NHFS (1993) findings about women's obstetrical history; that is, with respect to number of pregnancies, age, birth spacing, and live births.

[162] One of my key informants (TDG), also observed similar behaviour among *Dai*s during his tenure as a medical officer.

[163] *Beta, beta* means 'child, child.' It is a kind and gentle way of addressing a younger person by an elder, a child by a parent, or in this case, the woman by the *Dai*.

> *It does not matter if the behn [Dai] has taken training from SEWA or the government. We will listen how the behn teaches, advises, how she looks after others, and what is her nature; then we will decide if she is a good Dai.* (Vbehn)

> *Even if she has not taken any training, but if someone had their delivery by her, then we will know if she conducts deliveries well and that she has done them. Otherwise, how will we know?* (Bbehn)

*Dai*s were called when these clients experienced problems such as vomiting, back pain, nausea, and bleeding; otherwise, they were called when the women experienced labour pains.

A deputy *sarpanch* of Village A said that the *Dai* of her village conducts deliveries better than a doctor because she is experienced (DSbehn). Furthermore, she said, this *Dai* is willing and ready to assist in the village health work and other events. All interviewed said that *Dai*s do not maintain or observe caste delineation. The *aganwadi* worker of Village A explained, *"We have only one Dai in our village, and she goes to all the mulhollas (neighbourhoods), to Harijan, Thakor, Patel, etc. She is kind and goes to the Vaghri place"* (Aganbehn).

Sbehn, a client of the *Dai* in Village A, said, *"She has been working as a Dai for twenty-five years and is experienced and considerate."* However, one client, who had deliveries by both the trained *Dai* and the FHW, mentioned that both of them had applied fundal pressure on her abdomen during the delivery, and the *Dai* had applied hot *ghee* on the cord stump (Jbehn). Vbehn, who had deliveries conducted both at a private hospital and at home, said that she did not feel any difference in the way the births were conducted. She indicated that two female housekeepers conducted her hospital birth in Ahmedabad City. The doctor was not present during the birth. The only difference, according to her, was that doctors give injections and *Dais* provide *utkaaro* (a hot drink made of black pepper and ginger with brown sugar to stimulate contractions) to hasten the births.

All participants, including members of the VDG, were in agreement that *Dai*s provide services to women regardless of the amount and mode of payment. They accept whatever they are paid. In fact, they said that at times *Dai*s themselves spend money to help these families. However, one of my key informants (TDG), who had worked in the villages and now volunteers to provide free health services in villages, said that in many instances this was not the case. According to him, *Dai*s negotiate their fees before going to deliveries. They also do not accept less than Rs. 50 per delivery, and in cases in which the family does not pay, *Dai*s exert subtle pressure to obtain payment (TDG). This informant provided some reasons why families do not want to pay a high fee. One reason is that families are fearful that the *Dai* may raise her demand during emergencies, and they may not be able to pay her. The other reason is related to the notion that *Dai*s' work is socially polluting, and therefore her work is not valued. However, he could not explain why similar work performed by biomedical personnel could be socially prestigious. It seems that there are multiple views on how *Dai*s negotiate their incomes. Participants noted that, apart from delivery work, *Dai*s are an important source of health information. One *sarpanch* of Village K explained it this way:

> *For any health campaigns and health check-ups, the Dai informs the villagers through us during the village meetings or when the women go to the aganwadi or the Mahila Mandal. And if she knows that someone is unwell, she informs the doctor and the nurses when they come about this individual.* (Sbhai)

The important contributions of *Dai*s in villages were emphasised again by a teacher-principal of Village A. He observed that rural health is a neglected issue because health workers are not keen to be in villages. He said:

> *Those who are in the health care service, such as doctors, nurses [FHW/FHS], and other health personnel, must be made to work in the rural areas where people need them. They do not fulfil their obligations to serve in the villages. People have to go to private doctors, and they borrow money to seek treatment. There are no health care workers living in this village, so in the case of emergency, we have to travel far to seek treatment. The FHW only provides vaccinations and medications [to children and women], and she does not attend deliveries here. So Dais are helpful to us not only in delivery, but also in basic primary health care.* (TeachbhaiVillA)

Just as with the health workers, I was interested to know what the villagers thought about the notion that *Dai*s would be phased out in the future. All said that this would not augur well for the villagers. Their views echoed those of the health workers about why *Dai*s would remain, although some noted that even if they were not around there may not be a huge loss. Those who said that *Dai*s would be around in the future felt that those who do good work would continue to be needed. Furthermore, not everyone can afford to go to a doctor or afford the transportation fees, even if vehicles are available. So the *Dai*s are needed to help poor people and in the event that women cannot reach hospitals on time. A teacher noted, *"During the monsoon season roads are* *impassable. It is difficult to travel, and you cannot get help immediately"* (TeachbhaiVillV). According to the deputy *sarpanch* (DSbehnd):

> *If there are no Dais, people have to go to hospitals or clinics. However, in many instances, getting to the hospital or the clinics is not easy, and sometimes the woman and the child die because they could not get there sooner.*

> *It will be a loss if one day there is no Dai. Those who can afford, who have money, they can go to private hospitals or clinics; but those who are poor, they have to borrow money. It is for the poor that the Dai must continue her work.* (Jbehn)

One client, however, said:

> *I personally will not feel the loss if there are no Dais. I can go to the hospital to give birth. But if a Dai is available, then it is convenient and less expensive. If there are no Dais, then there is no alternative. And if you do not have money, then you have no choice but to borrow money and go.* (Sbehn)

A member of a *Mahila Mandal* noted:

> *Dais are good to have around. But it is good for the delivery to occur in hospitals because you have all the equipment there and it is cleaner. Nowadays there are many hospitals and clinics, and people prefer to go to hospitals for delivery. People's understandings have changed. . . . Now they do not see this [conception and birth] as kudraat [nature], but something where there can be problems. So people are going to hospitals even when they cannot afford to. So I think slowly, slowly Dais will not be around.* (MMbehn of Village V)

Summary of Perceptions of Clients and Village Functionaries of Dais' Contributions

Those who live in the villages said that *Dai*s are needed. Although there are clinics and hospitals, they may not be accessible, especially during the monsoon season. In other cases it may be due to the cost of travel or lack of staff at the public hospitals or the cost of hospitalisation. The testimonies of the clients indicate that there may be some *Dai*s who practise certain harmful methods, which seems to support FHWn1's observations, but these testimonies also show that those who teach the *Dai*s not to practise fundal pressure do it themselves. In addition, deliveries conducted at institutions do not necessarily mean that women have access to expert care, as in the case of Vbehn, although it is difficult to generalise from one experience. However, her experience supports the observations of urban *Dai*s that *ayahbehns* (housekeepers) and not doctors conduct the deliveries in private clinics. In regard to the future of *Dai*s, the data from the interviews seem to point to a common perception that *Dai*s will be around as long as they meet the needs of the population, especially those who are poor. And one client noted that the *Dai*s' presence provides an alternative to institutional births.

Perceptions of *Dai*s' Work by Their Family Members

Family members include husbands and sons of the *Dai*s.[164] I did not purposely exclude the female relations of the *Dai*s. Female members such as daughters and daughters-in-law were reluctant to be interviewed because they were uncomfortable speaking about delivery and birth in front of the *Dai*s. As noted, delivery work is often undertaken when women are older, and it is not socially acceptable to speak openly about this topic either in front of an older individual or if one is unmarried. However, my questions aimed at understanding the impact of *Dai*s' work on the family and did not refer to any intimate aspects of delivery. Male family members, however, did agree to be interviewed. In the end this was advantageous because I was able to understand the decision-making process and the power relations in a patriarchal society.

*Dai*s' family members provided a different understanding of their work and how it affects them. There were certain commonalties both among themselves and with the previous groups. Observations such as that the *Dai*s do not maintain caste delineation, are helpful, accessible, and accept all types of remuneration were expressed consistently by members of this group. That the *Dais* are trusted by the people and in some cases by the health workers and officials was also a commonly expressed theme. The husband of one of the *Dai*s said, *"People consult her in the*

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[164] I have opted to protect the identity of those interviewed because I wish to avoid any potential harm that may come to them as a result of the information they provided to me. Lbhai is the husband of SMeh7. He is about 50 years old, works on his own farm, and studied up to Std. 3. Dbhai is the husband of NSMeh26. He is 60 years old, studied up to Std. 5, and works as a tailor and a night security guard. Cbhai, aged 64 years, is the husband of SMeh8. He is unemployed and suffers from poor health. JRbhai is the youngest of three boys, son of SMeh22. He is 27 years old, has been married for three years, and has no children. He is a weaver and has studied up to Std. 11. JMbhai is the youngest son of SMeh7, who has four sons. He is 18 years of age and currently (in 1999) studying in Std. 12.

village. And if there is any health work that needs to be done, then the MO and the district health officials meet with her through the FHW" (Dbhai).

However, the way that the participants in this group described *Dai*s' work differed compared to other groups. In this group, *Dai*s' work has assumed a godly nature. Words such as *dharm*, *poonya ka kaam*, *guru*, and *shanti* are found throughout the interviews.[165] They did not see the ritual pollution of birth work, but rather the act of helping those who need it. The words portray this clearly. The husband of one of the *Dai*s observed:

> *It is a work of dharm. What else can you say but this is good work? When someone tells you that you have helped them, and we have helped to alleviate their financial burden. For example, when the doctor comes he will charge Rs. 500, but we do not ask; we take what they give.* (Lbhai)

He provided another explanation as to why he felt that his wife's work as a *Dai* was a good deed; namely, that it is the *Dai* who guides the baby through the birth canal. Once the child is born, it is the *Dai* who speaks to the child and whispers the first few words of a sacred *mantra*. This is a *guru's* work. The son of a *Dai* said that he and his family are in good health and experience *shanti* because his mother provides free services to people (JRbhai). On the other hand, family members also mentioned that *Dai*s do not receive adequate remuneration for their work, even when the woman's family is able to afford it. The husband of a *Dai* pointed out:

> *There are some people who have money but do not pay us. . . . If the doctor comes, they have to pay at least Rs. 500, but when we ask for Rs. 51, they do not give it. So we take if they give gladly; otherwise we do not ask.* (Lbhai)

He further revealed that the FHW in his area charges fees when his wife, the *Dai*, attends deliveries. According to him:

> *When she [FHWn1] is called to attend the delivery, she immediately asks for Rs. 300 from the family. She would make my wife do the work, and she receives the fees from the family. On paper it will be the Dai who receives the Rs. 25-100, but in actuality it is her [FHWn1] who receives the payment. So what can we do? And when she [FHWn1] is not paid immediately, she tells the Dai that she has not been paid, so in this situation we [the Dai] do not ask for any payment.* (Lbhai)

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[165] *Dharm* refers to religious duty, *poonya ka kaam* means work of blessing, *guru* is teacher, and *shanti* is peace.

Only Lbhai indicated that there was some form of caste delineation practised by certain segments of the population in the village and by the FHW. This is the same FHWn1 who during her interview had said that she did not practise caste discrimination in her work. However, Lbhai noted, *"The FHW does not come to our mulholla [neighbourhood]. We have a good relationship, so when she [the Dai] calls her, only then will the FHW come; otherwise, she does not."* Bbehn, who is of the same caste as Lbhai and a client of the *Dai* (SMeh7), supported his observations.

All family members voiced their concern for the safety of the *Dais*, especially when they have to attend deliveries at night. The son, JR, said that he usually accompanies his mother unless the individual who comes to get her is known. The husband of another *Dai* said that when he works at night, his son takes her. Otherwise, he accompanies her to the place of delivery (Dbhai). Family members have learned to cope with the erratic time schedule related to *Dai*s' work. For example, the son of a *Dai* (SMeh7) said, *"My brothers and I have learned to cope when my mother leaves early for work or is away. We can cook simple meals for ourselves. We know she is doing good work"* (JMbhai). On the other hand, the household of Dbhai was able to function because his daughters took care of the housework when his wife was away at a delivery. And now his daughter-in-law has assumed the household responsibilities.

Family members of Lbhai and Dbhai felt that *Dai*s' work will continue if younger women are willing to learn, which would ensure that skills and knowledge would pass down to the next generation. Lbhai observed:

> *I would not mind if my future daughters-in-law learn this work because it is a work of dharm. I hope this skill will be passed down from generation to generation because it will stay in the family. There will be at least five daughters-in-law in my family, and if one of them learned and carried on the tradition, then it would be good.*

One *Dai'*s son said that he would not mind if his wife learned the delivery work from his mother, but this would happen only once she was older (JRbhai).[166] Both JRbhai and JMbhai noted that as long as there are poor people in India, *Dai*s' services will be needed because not everyone can afford the costs of either institutional birth or long-distance transportation. In the case of SEWA *Dai*s, the organisation has tried to equip them with other health training so that they are able to complement their birth work and supplement their income. Non-SEWA *Dai*s do not have this additional health and income-generation training apart from delivery work. Lbhai said that his wife, with the assistance of SEWA, had also been involved in the construction of smokeless stoves and latrines in their village. The husband (Cbhai) of another SEWA *Dai* (SMeh8) of Village V indicated that every Saturday his wife makes her rounds "*just like a doctor*," and treats various ailments, such as fever, diarrhoea, coughs, minor injuries, and even malaria. She sells medications that she gets from the SEWA Health Co-operative to people at a low price (Cbhai). Although Cbhai thought that his wife is doing good work, he felt that she spends too much time outside the home instead of caring for the family.

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[166] Because sexual matters are not discussed openly, his statement has two meanings. First, being older means having experienced motherhood, which provides her with experiential authority. The other meaning is being older in age and therefore in knowledge and experience.

The husbands of SEWA *Dai*s regarded their wives' membership in the SEWA *Dai* co-operative as advantageous (Cbhai and Lbhai) because their wives have received the financial benefits, such as dividends, and regular health updates, such as refresher courses.

Summary of Families' Perceptions of Dais' Work

Dais' family members support their work in delivery. They perceive it as an act of service and not defiling.[167] Like the *Dais*, they said that the amount and the type of payment do not matter, couching it in terms such as service, godly work, and work of blessing. However, they observed the discrepancies in behaviour of families related to payment. They noted that families are willing to pay the physicians' high fees for their interventions, and yet appear reluctant to do the same for the *Dais'* delivery work. Family members voiced a concern for the *Dais'* safety when they are called at night to attend deliveries. Similar to the urban *Dais*, they have tried to address this in a number of ways, either going with someone they know or being accompanied by their own family members. With respect to the continuation of *Dais'* tradition, they felt that it would continue, as long as young women are willing to learn and carry on the work. Others mentioned that *Dais* would continue to be present as long as there was a segment of the population who could not afford to pay high fees for institutional births or high transportation costs. The families of SEWA *Dais* perceive *Dais'* membership in co-operatives as advantageous because of the opportunities to expand both income and knowledge. However, none of them mentioned whether the membership had enhanced the social or political reputation of the *Dais*.

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[167] This does not preclude the ritual involved in cleaning oneself. A *Dai* whom I observed conducting a delivery came home and was not allowed to enter the house. A family member had already prepared a bath (bathrooms and toilets are usually located outside the house) for her and brought a change of clothes. The *Dai* took her bath, including washing her hair, and then went to pray at the temple to *Mataji* (SAhd12).

Gujarat State and District Health Officials' and Researchers' Perceptions of *Dai*s' Work

State and district health officials and researchers provide various official perspectives of *Dai*s' work. Because they are involved in policy making, research, and training in health, their perceptions of *Dai*s' work provide some clues as to the *Dai*s' future and their potential role in RCH. As in the preceding groups, *Dai*s are considered to be important members in the delivery of maternal care because they operate at the grassroots level. That *Dai*s are accepted, accessible, and trusted by their communities was also acknowledged by individuals in this group. However, a senior medical officer, MO(Ad), noted that their acceptability is based on the fact that they are able to meet the community's needs and not because they are honoured socially. He put it this way:

> *The Dai does have her community's respect. In her community she is called 'Dai Ma,' nothing less. Her reputation is established. But when the work is over, then I do not think the community does anything special for her that acknowledges her contributions. I have not seen anything like that. While she is helping the woman, the family accepts her. She is taking care of the baby and the mother. But after that it is not like people touch her feet or do obeisance. After she has fulfilled her function, then it is all over.*

A retired senior health officer (RSHO), however, said:

> *These women [Dais] are very important. A Dai is accepted in that village and enjoys the confidence of the people and their trust. Even where the doctor is available, people usually go and call her first instead of the doctor. So she has her own clientele, and as a result, about 60-70% of births in our country are conducted by the Dais.*

Although *Dai*s conduct a large number of deliveries in rural Gujarat and India, their future in the state appears to be uncertain. The prevalent thinking at the official level is not to encourage the creation of new *Dai*s and the eventual phasing out of *Dai*s from the health system (HIASCGuj1). This high-ranking officer noted that the phasing out of *Dai*s would occur only if rural health services are improved and meet the needs of the population. He further said that *Dai*s are only a temporary solution and not a permanent one in Gujarat because the long-term goal is to move home births into public hospitals or other government-sponsored agencies (HIASCGuj1). However, views on achieving complete institutional births were divided. A senior health researcher provided reasons why this may not happen. He noted:

> *A complete shift towards institutional births will not occur because it is not cost-effective. People have to travel far, and those who are poor cannot afford it. So the solution is to ensure births [home births] are attended by trained Dais.* (DMG)

And the retired health officer noted:

> *Because there will not be anyone to take over the care after 2:00 p.m.*[168]*. . . and because the FHWs do not live in the quarters and everyone knows this, who will do the deliveries? So they [government] cannot stop this institution [Dais], because if they do, then it is a mistake because the Dai is the main caregiver. We are dependent on her, and we have to strengthen [her capabilities]. . . . So the best intervention is to utilise this resource who are from the community and who are accepted by the community. So if they are taught, if they are given some knowledge and skill about asepsis, then it will prevent IMR and MMR.* (RSHO)

In the RCH programme *Dai*s' roles in the health care system will remain the same as in the previous Child Survival and Safe Motherhood (CSSM; motivating family planning and immunisations). There are no provisions made for their increased participation or a change in their scope of practice. Another high-ranking health officer said that *Dai*s should not be considered as an alternative to the higher level of health providers such as FHWs or ANMs (HKGujAdd2). HIASGuj1 observed that the weak link in Gujarat's present RCH programmes is the continued dependence on the *Dai*s to provide maternal care despite the government's best efforts to improve the staffing and the physical infrastructure of rural health. RSHO noted that *Dai*s are not recognised for their contributions or made part of the health care system:

> *They [Dais] should be made to feel that they are part of the system. This has not happened. They [health care officials] regard the Dais as spare parts, excess spare: When in need use them; otherwise, we have no interest in them. . . . In the department [of health], though, she is the most important person. She is also the most neglected individual.*

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[168] She meant that there is no one at the PHC or the subcentre (unless the FHW lives in that village) after 2:00 p.m. Individuals are in the field or have left for the day.

However, similar to institutional births, perceptions of the extent and the mode of *Dai*s' participation in the health care system differed among interviewees. Although this health officer felt that *Dai*s' work is not recognised because *Dai*s are not made part of the health system, HIASCGuj1, on the other hand, noted otherwise. He felt that the Gujarat government's initiatives such as training, providing identity cards (ID cards), and providing remuneration are some of the ways that the government has tried to make them part of the formal health care system. Therefore, according to him, *Dai*s are now part of the health system:

> *There was a demand by SEWA and Dais that they should be issued identity cards so that they are recognised and that they can set foot in the PHCs and the Community Health Centres [CHCs]. They had been working in a private capacity, so if they were issued with cards, that would improve their acceptability. People already accept them, but if they work with doctors and primary health care providers, it will improve. Their status will improve. . . . But our policy is not to encourage new Dais. They [Dais] will feel that they are part of the official health care system and not outside. Previously they were working informally, but now with the ID card, the relationship with the government is formalised. So it is going to be very useful to them.* (HIASCGuj1)

HIASCGuj1 indicated that the purpose of providing *Dai*s with ID cards, remuneration, and training was to increase their visibility and legitimise their work. On the other hand, HKGujAdd2 felt that *Dai*s could use their ID cards to impress upon people that they are not just *Dais*, but *trained Dai*s.

The official perception of a *Dai* is that she is illiterate and poor and conducts deliveries that do not follow the methods of science. Thus comments such as, *"Dais' work is unscientific, and they must be taught to conduct deliveries in a systematic and scientific way"* (MO[Ad]); and *"There are two groups of Dais: scavengers and birth attendants"* (Dr. Shashi Vani) are found.[169] Based on these understandings, *Dai*s have, over the years, been involved in various training programmes. In 1998 the Minister of Health, Mr. Ashok Bhatt, and his ministry, concerned about Gujarat's high maternal mortality rate, organised a seven-day health event, out of which two days were devoted to training 24,000 *Dais*.[170] After the training *Dai*s were given picture identity cards and the *Dai* Delivery Kits (DDKs). The state government further increased their remuneration from Rs. 10 to 20 for each normal delivery conducted and gave a further Rs. 50 referral fee if the *Dai* referred an at-risk delivery to hospital. According to the health officials, the objectives of remuneration were twofold: first, to motivate *Dai*s to make early referrals of any complicated pregnancies or deliveries; and second, to give *Dai*s the incentives to follow aseptic methods when conducting deliveries (Mr. Ashok Bhatt; HIASCGuj1; HKGujAdd2). There is a chance that the state government will increase the rate of payment, but this will depend on the available funding. A second change that could occur is the inclusion of gloves in the DDK.

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[169] This delineation was made by the Head, Department of Paediatrics, Civil Hospital, Ahmedabad, during the discussion at a State Level Conference on RCH in Gujarat (1999). She made the point that even within *Dai*s' work there is a hierarchy. State-level health officials included Gujarat's health minister, and members of various NGOs attended this meeting. I attended this conference, which provided me with the background for my research.

Despite training, the issuance of ID cards, and remuneration, *Dai*s appear not to have achieved increased social status or political control. In addition, it seems that caste is a factor that affects their work. But as participants noted, caste is negotiated among individuals to meet their needs. The senior health officer and others made the following observations about *Dai*s' social and political positions, their work, and caste:

> *Community members know that she is a useful person, so that gives her some importance. Otherwise, she is poor and usually has no other source of income. And if she is from the Scheduled Caste, then due importance is not given to her. Because her services are needed, then even a Brahmin family will forget that she is a Harijan.* (RSHO)

> *The traditional Dais, . . . there is a stigma attached to this work. People do not want to do this job.* (DMG; MO(Ad); SB)[171]

> *As far as Dais' social and financial status is concerned, we cannot say that they are well off or well placed. Even when they do their work well, it does not mean that they will be compensated or that people will have high regard for them. They do not have any political power. In our social structure, the Dais are from the lower strata, with low economic status, and are poor, and that is the way it is. They are accepted at the time of birth, and after that whether they are alive or deceased, nobody bothers about them.* (MO[Ad])

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[170] The health minister linked the safe motherhood event to the *Navratri Mahotsav*, the worshipping of Mother Goddess. In doing so, he wanted to create awareness among people about women's health issues related to motherhood. This event was known as *Ma Raksha Mahotsav*.

[171] SB (personal communication, August 1999) is a *Vaid* (*Ayurvedic* physician) working in an NGO based in Ahmedabad. She has worked with *Dai*s extensively.

According to a senior health official, it is because of the efforts of the government and NGOs that *Dai*s have received remuneration and other benefits (HIASCGuj1). Otherwise, he said, *"Who would bother about these women?"* (HIASCGuj1). The RSHO noted that the other reason could be that their work reflects India's traditional *jajmani* system, where members of each caste have inherited specific trades and services. This ensures that knowledge and skills are passed down from one generation to the next, but it does not have the prestige of biomedicine because *Dai*s' work is linked to tradition and is therefore not scientific.

> *This work runs in the family. In fact, our whole economic system is based on this tradition. For example, a carpenter's son would learn the trade and become a carpenter, or a goldsmith's son would take over his father's work, so likewise in some families the Dais who do the deliveries take their daughters-in-law or daughters and teach them. That is how the knowledge is passed down, and these women inherit that. And it is not that their traditional knowledge is incorrect, but it is just that they do not know the scientific principles.* (RSHO)

Only one health official mentioned that *Dai*s are good agents to initiate changes both within their families and in the communities MO(Ad). Others focussed on how the training of *Dai*s would benefit Gujarat in the context of decreased IMR and MMR and safe motherhood. However, none of them discussed the impact of work and remuneration on *Dai*s' well-being.

> *Because she is in contact with the mother-in-law and with the family, she is an important link for health actions. We include her in immunisation work and tell her why it is important.*[172] *So she knows and she plays an important role. And her work is not limited in this area but includes teaching women the importance of breastfeeding, especially the colostrum and weaning diet.* (RSHO)

Summary of Perceptions of State Health Functionaries

The *Dai*s' role in RCH would remain the same as in CSSM. The *Dai*s' primary role is to conduct safe and clean deliveries, motivate women to adopt the various family-planning methods, and assist in children's immunisation and prenatal care. It appears that *Dai*s do not have any new responsibilities or roles in RCH such as decision making or involvement in new health initiatives.

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[172] People were afraid of immunisation because their children would develop fever following the vaccinations, and they thought that their children were ill because of the vaccines.

For example, one of the senior health officers (HKGujAdd2) did not think that *Dai*s could assist in the dissemination of information regarding HIV/AIDS because of their illiteracy. He noted that they may not be able to grasp the facts of the disease, and therefore the accuracy of the message may be in doubt, although he acknowledged that *Dai*s are involved in disseminating other health messages such as those above.

The state government's concerns about the creation of new *Dai*s shows that it ignores the fact that there are two systems in which learning and teaching of *Dai*s occur. By focussing on one system, the biomedical model of imparting knowledge, the health officials of Gujarat have failed to consider the role of the indigenous way of transmitting knowledge and skills and its own perception of work. The health officials ignored the fact that *Dai*s are not 'created' through the formal training system but through other learning systems such as apprenticeship, imitation, and helping older, more experienced *Dai*s, whereby the knowledge is passed from one generation to another. They are already found even before the *Dai*s receive the biomedical training.

Health officials have placed the onus on the *Dai*s to do early referrals. However, they have not taken into account that women usually do not ask for assistance or see *Dai*s until they are ready to deliver. Based on the current scenario, it means that the *Dai* will see this woman during her delivery. Although she may refer if there are any problems during this time, she will not, however, be able to refer the woman early if she has not seen her before. The *Dai*s are caught between two systems of birth management, the biomedical system, which assumes that all women visit *Dai*s or participate in prenatal care; and the indigenous system, which assumes that birth is a natural process, and therefore one should seek help if there are any problems.

SEWA's Perception of *Dais*' Work

Mirai Chatterjee, Chair of the SEWA Health Co-operative and coordinator of SEWA's social security work, explained that SEWA's entry point into any community work is addressing women's economic concerns:

> *Well, it has to do with the fact that the choice of our entry point is economics. We organise women on economic and basic survival issues. For many women even before they can deal with health issues, their concern is economic survival, issues such as work and income security. They want income in their hands. Whatever little income they can get in their hands, whatever funds they can manage to scrape up to buy medical care and get some measure of health security. The reality is, without income and work, they starve*

> *and die, and it is as brutal as that. So I think the reason they [women] trust SEWA is because SEWA starts with what is nearest and dearest to them, which is the economic, which we see again and again, that women want employment, women want work security. Then everything follows. So the choice of intervention, if you will, is organising on the basis of work.*

As a union that supports self-employed women engaged in various services and trades, SEWA's work with *Dais* fits well with its overall philosophy enshrined in its 10 points (see Chapter 4). Mirai articulated SEWA's vision of good health, the reasons why the organisation links it to work and income, and why it actively promotes the work of the self-employed women in the mainstream:

> *For us, health security is part of social security, and social security is part of our main goal of full employment. So we feel that we cannot have full employment and self-reliance, SEWA's two main goals, until we have health security. I mean, health is an economic input. It is not separate, something out there. We cannot have health security until we tackle the problems of poverty, because whatever is earned is spent on illness, and ill-health is a major cause of indebtedness among our members. Thus our whole thrust has been economic empowerment, and health is part of economic empowerment.*

However, Mirai observed that achieving a balance between income and work security and health is a delicate one because, on the one hand, even when women know that the work they are doing is harmful to their health, they continue to work because they have no choice:

> *I think it is very hard to know what to do to intervene to improve women's occupational health status, largely because they need that work for survival. And if it ruins their health, so be it. For a health worker it is very painful to watch because you know that exposure to tobacco is definitely toxic and harmful, but there are no alternative employment opportunities. Of course, SEWA is trying to change the situation and build alternative economic opportunities, but until they are viable and bring in good income . . . . So, you know, we are talking down to the wire here, women living in poverty, below poverty. So their first priority is constant work, employment and income. And if their health is ruined in the process, so be it because they have to feed their families. They say, "Well, what do you want us to do about it? Do you want us to stop and not work?"*

Because of its historical beginnings, the organisation constantly explores alternative employment opportunities or tries to create alternatives for women within the existing political and socioeconomic structure. As discussed in Chapters 4 and 5, self-employed women's contributions are often undervalued or ignored, and they are not paid according to the amount of work they do. For example, SEWA found that in remote rural and certain peri-urban areas, maternal and basic health care are either inaccessible or nonexistent. In these cases, *Dai*s are the ones who provide affordable and accessible care to women in their communities, in addition to having the trust and confidence of these individuals. SEWA health supervisors[173] working in nine districts, and health coordinator Mittal Shah noted, "*When we were in the field we saw that the majority of the deliveries were conducted by the Dais.*" Mittal also observed that at the present time, SEWA and non-SEWA *Dai*s are already performing some of the health tasks that are carried out by the government health providers such as the FHWs. Apart from delivery work, SEWA *Dai*s motivate individuals for immunisations and family planning, do referrals, maintain records of their work, provide primary health care, and in some cases dispense medications. In addition, SEWA *Dai*s are taught to provide health advice to women, and they assist in organising mobile health clinics in their areas according to the communities' needs. Unlike the Gujarat health officials, SEWA believes that *Dai*s are capable of carrying out multiple health work, and they should not be limited only to delivery work. SEWA is working towards equipping its *Dai*s with other skills and knowledge, such as those regarding various primary health care diseases and treatment and, in particular, increasing awareness of the diseases and illnesses that affect women. SEWA wants to train the *Dai*s to become the barefoot doctors of their communities. Based on these observations, SEWA advocates the inclusion of the *Dai*s at all levels of health care because they are the grassroots health caregivers.

> *We perceive Dais as central, pivotal to the whole [health care], not only to birthing and women's health, but health in general in the communities. Our Baseline Surveys show again and again that one of the most vulnerable points of women's lives is during*

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[173] Shehnaz, Roshan, Madhukantha, and Madhu are some of the SEWA health supervisors who have trained the *Dai*s in SEWA. They oversee health work in the district(s) to which each supervisor is assigned. They are members of the SEWA Health Co-operative. All of them began work in other SEWA initiatives before joining the health team. Their membership in SEWA ranges from 10 to 20 years; all except one are unmarried. Their education ranges from baccalaureate (in sociology) to Std. 3. They all described being transformed when they joined SEWA from being afraid and unsure to being able to face challenges. Madhubehn's account describes this transformation well:

> *My upbringing was such that I had never boarded a bus, and I did not even know the bus routes or which bus to board. Even when they [SEWA] sent me to do work within the city, I did not know where that place was. So I would write the name on a piece of paper and go home. Then I would say to my family members that I want to go a certain place, and so please take me there. And they would accompany me there and back, and I got lost many times, but now I go anywhere on my own.* (Focus group interview, September 18, 1999)

For Shehnazbehn, her work in SEWA has assured her a stable income and employment. Before then, she struggled to make ends meet.

> *childbirth. But women also suffer from many major illnesses that are preventable, such as communicable diseases. So we think that Dais can be a focal point for all kinds of actions and initiatives at the local level. In that way women are taking care of their own health. We would like to strengthen the idea that women themselves learn how to be healthy rather than having health care provided or delivered. So it is a process. Ideally, we need to take care of our own health and not have someone take care or deliver health care to us. And Dais are a logical base to start from because Dais, as I said, are central in the village. They enjoy the confidence of the people; they are the people; they have proven their worth; they are skilled; and also they are among the poorest in the village; and they are women. And for all those reasons Dais are a good place to start. Also the thrust of our government is RCH, and how can you do RCH without involving the Dais? I mean, it is impossible. And the other thing is that there is an unacceptably high level of child, maternal, and infant mortality rates amongst the poorest, so if something has to be done, then the Dais necessarily have to be involved.* (Mirai)

However, Mirai noted that *Dai*s' integration in health care is an ongoing process and that once the bonds with the formal health system are strengthened, this could change. For the above reasons SEWA feels that *Dai*s should have a greater role to play within this framework. In the *Dai*s' case, their increased role would ensure that they are involved in formulating policies that impact their employment and income.

Using similar strategies to those that the SEWA union has used to mobilise other self-employed women, the Health Co-operative began its promotion of *Dai*s by issuing identity cards (ID) to them with their photographs. This card was initially issued by SEWA to SEWA *Dai*s who had completed their training with SEWA. The ID cards legitimised their work and their training. After six years the state government implemented the idea at the state level by issuing photo ID cards to all *Dai*s (both SEWA and non-SEWA).

> *Well, because we are one of the biggest labour unions, one of the main problems that women workers face is the issue of visibility. SEWA has been campaigning for a long time to promote the visibility of workers. And one way to do this is through the ID cards, whether as a construction worker, a vendor, or a bidi worker. So we thought, Why not the Dais? They too suffer from the same problem of nonrecognition and invisibility, and therefore their contributions are not valid or recognised. So we started a campaign five years ago for the recognition of Dais as legitimate health functionaries at the local level. So somehow or other the [Gujarat] Health Minister picked up the idea, and that is how the photo ID came into being. That is totally, if I may say in all humility, a SEWA innovation. We did a campaign, and it took us five to six years, and we are the first state in the country to have ID cards for the Dais; we are the first.* (Mirai)

Both Mirai and Mittal noted that the state ID cards increased *Dai*s' self-esteem and established linkages with the formal health system, *"They were very pleased; it is like a passport to them, and increased their value among people"* (Mirai). It also led to *"their names being added in the government registry, so they will be paid"* (Shehnaz). SEWA leaders believed that enhancing *Dai*s' visibility is a priority because it would publicise their contributions to the health care system, which could lead to an increase in *Dai*s' income:

> *First, their work and income security should be secure so that they can begin to eat properly, and then it seems that health comes up very quickly on their list of priorities, and we are seeing that now. . . . I would like to see working-class women managing, controlling, and using their own organisations. I think it will happen sooner than later that women from each district will be managing their own organisations and associations. Also, I would like to see all Dais in our state organise with their own ID cards be given the recognition that is their due, the respect that is their due, and receive the kind of training that they would like.* (Mirai)

Apart from the above, rural *Dai*s report that even when the families do not pay them, at least they receive Rs. 20 from the Primary Health Centre when they register the births and show their ID cards.[174] A SEWA *Dai* in Ahmedabad City related that, during a riot, she was stopped on her way to a delivery (SAhd13). When she showed the policeman her SEWA ID card, he allowed her to pass the barricade.[175] A non-SEWA *Dai* in rural Mehsana was given a ride in a vehicle for free when she showed her ID card and informed the driver that she was on her way to a delivery (NSMeh30). Although SEWA feels that the ID card is a step towards visibility and a recognition of *Dai*s' work and learning, other health officials who have worked with *Dai*s say that despite the issuance of ID cards and training, *Dai*s have not gained any tangible benefits socially, politically, and economically. They continue to be in the margins (MO[Ad]; RSHO).

As noted in Chapter 4 above, SEWA has embarked to increase the *Dai*s' visibility is setting up a training school. This is another idea that the Health Co-operative had adapted from the SEWA union work. SEWA believes that women have to learn new knowledge and adapt to changing times in order to compete with the demands of the local and overseas markets. Therefore the aim of the *Dai* School is to provide the *Dai*s with the opportunity to enhance their knowledge and skills through a structured training programme so that they can adapt their work in the evolving health care framework.[176] The Health Co-operative hopes that its two-pronged approach of establishing a school and the *Dai* co-operatives (discussed above) would make a difference in the *Dai*s' income, work, and social status. SEWA's attempt to establish a *Dai* training institution follows a similar model to that of various biomedical practitioners, each having individual training institutions and specialised curriculum. A formal school would establish the *Dai*s' legitimacy to their knowledge and therefore promote their work along the lines of professionalism. Legitimacy through professionalisation would enable the *Dai*s to become more confident in determining their fees and charging their clients, therefore obtaining regular income and employment. Mirai confirmed that regular income and the ability to control their income is one way of increasing self-esteem:

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[174] Initially, the Rs. 20 was given only to *Dai*s who had received official training; that is, training through or by government health functionaries. SEWA lobbied hard to remove the division. In 1999 SEWA-trained *Dai*s were issued with government ID cards (in the beginning they were given only to *Dai*s in Ahmedabad District). Later this practice spread to other districts. But the *Dai*s in Ahmedabad City do not receive Rs. 20 or the Rs. 50 or the ID cards because they are under the jurisdiction of the Ahmedabad Municipal Corporation.

[175] Although SEWA *Dai*s in Ahmedabad City said that their SEWA-issued ID cards were useful in removing obstacles, these cards are not recognised by the AMC officials.

> *We [SEWA] are moving towards having a school for Dais so that they will get proper, modern training in obstetrics and, at the same time, respect their indigenous and very relevant skills and knowledge. So apart from expansion and deepening [SEWA's health work], we want to see that health moves more and more into women's hands.*

However, Mirai noted that eligibility criteria will not be based entirely on literacy level:

> *I don't want the literacy stuff to get in the way. One of the criteria have to be how active they are and their willingness to learn. Off the cuff, that would be my two criteria because many of them are not willing to learn, as we know. I think we will sit down with them and obviously do it [design the curriculum].*

During the discussion around setting up the SEWA *Dai* School, Mirai (and others in SEWA) felt that *Dai*s should and could be taught new skills and knowledge to upgrade their practice[177]:

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[176] The school was still in the planning stage when I left Gujarat on February 24, 2000. Since then the school has had a few intakes of *Dai*s from both the city and other districts (Mirai Chatterjee, personal communications, January 16, 2001). However, since the massive earthquake in 2001 and the political upheavals due to religious differences in Gujarat in February 2002 (and still continuing), where curfews have been imposed in various parts of the state, I am unsure how the operation of the school has been affected.

[177] See Hochwald (1985) for further discussion about the barriers that women face when accessing or learning new skills.

> *We thought we would add primary health care to their training so that they are not just limited to midwifery, and they could become the communities' barefoot doctors. We also want to equip them with more solid knowledge and information on drug dispensing in primary care. . . . We would like to strengthen their hand and make them as capable as possible, strong as possible, as technically competent so that their skills are built up; and as you heard today, we would like to see midwifery develop as a form of self-employment.*

Aware of the importance of social prestige and standing in society and of creating various economic niches to earn income and for work security, SEWA intends to train these women to learn other skills so that they are able to function as community healers and leaders:

> *Well, I think we can teach Dais how to take BP [blood pressure]. Our experiences have shown that paramedics,*[178] *health workers, illiterate women [have been able to learn and do]. I mean, taking BP using a stethoscope is possible, and to give primary medications under supervision and with constant follow-up and support. They [Dais] should be checking for urine [urinalysis] using the urine stick. We have been able to do that with Dais earlier, so I do not see why we couldn't now.* (Mirai)

SEWA will use its health trainers to teach the *Dais*. A female gynaecologist has been hired by SEWA to provide guidance to these trainers. Mirai explained the reasons behind this move:

> *They [trainers] would be our own in-house faculty. That is how I see it. They have been doing a lot of Dai training, and they have a good rapport with the women [Dais]. They are sensitive to their [Dais'] needs. They [trainers] know our approach, which is respecting Dais' knowledge and not just going in there and saying whatever you like. So we would like such a person to be in there. . . . The other thing we would like to do is to establish more linkages with the government so that right in the beginning they will be in the mainstream rather than in the periphery.*

Indeed, SEWA's work of mobilising women into the mainstream economic structures has taught SEWA organisers that the pursuit of an alternative path can at times isolate women. No one is more aware of the consequences of alternatives and isolation than Mirai. She and other SEWA leaders emphasised the need to link the SEWA *Dais* and its fledgling *Dai* School with government structures so that women are not isolated but become integrated within mainstream health care to reap the benefits of their work and contributions. She said:

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[178] See Chapter 5 for a definition of paramedics. In the past SEWA ran a six-month nurse auxiliary training programme in collaboration with hospitals in Ahmedabad. This programme has since been discontinued.

> *Somehow we have to get the official certification, and that is going to be tough. But at least we can get the government to pass the order that this is a recognised school for the Dais. And maybe we can have some of the government people [tutors] to run some of our training programmes. We want the Dais to learn in the same system that they [the Dais] received the ID cards from so that their benefits will flow in [and] the linkages are established. We do not want to be too alternative, because then you are out of the mainstream, then you are shut out, [and] doors are closed. So what Elabehn said in the meeting—"a healthy distance, but at the same time remain connected."* (Mirai)

In the long run, the *Dai* school could add more recognition to SEWA's other groundbreaking work in mobilising self-employed women and empowering them using the structures of the mainstream without further marginalising the *Dai*s.[179] Because the contribution of self-employed women is often invisible, the school, together with other SEWA initiatives, has the potential to bring their contributions to the fore. Although SEWA's work with self-employed women has led to various policy changes, these changes have not been made without struggles (Mirai, Lalitha, and Jayashree,[180] personal communications, 1999). However, when SEWA leaders hear the positive personal experiences of women, they feel that their struggles are worth the effort. SMeh8's self-confidence in her work and her relationship with the female health worker (FHW) in her village reflects the positive impact of SEWA's capacity-building work in women's lives. She is able to assist the FHW and is keen to learn new skills from her. She expressed her confidence with the following observation:

> *They [SEWA and FHW] have taught me to give polio drops. They have taught us for the first time how to give injections. I have given injections and also tried filling medicine with it. I am afraid to give it to children, but I can easily give it to adults. But I gave it to children with her (FHW) standing by me, never by myself. I cannot give an injection just anywhere but where there is no bone. And so there is no difference between the nurse [FHW] and me except she has the instruments and I do not, and she wears white clothes and I wear different colours. Otherwise, she does good work, and so do I. Both of us are women, and we do Dais' work. I too can give injections, and I work at the centre [SEWA's health centre],*[181] *and we both conduct deliveries.* (SMeh8)

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[179] Like all social advocacy work, there are pros and cons. I discuss the disadvantages of formal schooling and a move to become mainstream in Chapter 8.

[180] Jayashree Vyas is the director of SEWA Bank.

[181] SEWA has set up small dispensaries either at the homes of the CHWs or in a rented space to ensure the accessibility of primary health care drugs and other treatment. This move aligns with the PHC objectives of accessible and affordable health through decentralisation.

This SEWA *Dai* further observed:

> *The people in my community respect me. They like my work, and they are happy with what I am doing. They think that it is good that I have learned all this. And they say that it is good that SMeh8 is working for health care, and she will teach other women. People say that SMeh8 is very intelligent. In other villages people say that if you do not want to go to the hospital in Kalol, then SMeh8 is a doctor and she is an expert in delivery work, so you should call her and she will come.*

Summary of SEWA's Perception of Dais' Work

SEWA's philosophy is that women should become self-reliant and gain full employment. The organisation assists women in learning and upgrading their skills and managing their own co-operatives. It is through the co-operatives that the organisation tries to bring about changes in women's economic and social status. This is because SEWA believes that once women have work and income security, they will then be able to address other social and political issues. Thus the organisation moves beyond the economics and focusses on building *Dai*s' capacities. In doing so, SEWA concentrates on *Dai*s' well-being as workers and as women and not merely in the context of population statistics of IMR and MMR, which many government and international agencies do.

SEWA leaders observed that it takes years of capacity-building work before they see any tangible changes in poor women's health and income. This is because women suffer from low self-worth and are often in the margins. According to Mirai, their low position is reinforced by the social values in a patriarchal system. Mirai provided two examples of how this low self-worth is manifested: first, the way that food is allocated; and second, access to health care when women are ill. She noted:

> *The fact is that women eat less than other family members even when they do equal work. So not only do women not get equal pay for equal work, but they do not get equal nutrition for equal work or more work, so I think that has been our [SEWA] contribution to the public. I think it is the result of gender relations and patriarchy in our society. I think it is deep-rooted gender bias in our society, and women culturally are socialised at a very young age that they feed the men and children first, and whatever is left, they eat.*

In regards to health-seeking behaviour, Mirai noted the following:

> *But for themselves they are the last priority [seeking treatment]. I mean, they are literally down to their last wire, on their sickbeds before they seek care. This is a major issue at SEWA, and it has to do with patriarchy. Women simply do not have a concept of self-worth, and this is where SEWA comes in and tells them that "you are worth it and you are important. Your contributions to the family are critical, and you have a right to care." This is the kind of messages that we have been trying to promote to our members so that they seek care. There is no health-seeking behaviour among our women members because they just do not see themselves as a priority.* (Mirai)

Thus SEWA's efforts in promoting women's work and income security have ramifications for gender relations not only in the present but also for the future. For example, it could influence the way *Dai*s and other women teach their children about creating equitable gender relations while at the same time addressing the current inequity. Mirai felt that SEWA's future work lay in building women's capacities so that they become empowered to initiate other changes in their lives. She said:

> *I think our major issue is capacity building—capacity building of the local health organisers and at the same time trying to improve the quality of health, because it is not just numbers we are talking about, but these are bodies, not abstract ideas in space. So women have to feel wanted, have to feel loved; then they can be healthy. So this atmosphere of love, trust, caring, and healing must remain at all times, so right now there is a massive capacity-building exercise that is going on [at SEWA].*

In the case of the *Dai*s, SEWA's initiatives such as a *Dai* School and co-operatives is a move to build *Dai*s' capacities. Furthermore, these initiatives are recognition that *Dai*s' contributions have a place in Gujarat's health care system. But more important, it is the belief that there is a close link between their position as women and their economic and social status, and that correcting one would have an impact on the other. Last but not least, SEWA's work shows that the concepts of RCH and HFA need not remain abstract, but can be concretised. This is possible if the changes are from the bottom up.

Conclusion: Multiple Perspectives Give Greater Understanding of *Dai*s' Work

This study of multiple perspectives on *Dai*s' work provide a better understanding about their contributions and position within the health care system. It moves beyond the strictly statistical valuation of their work. Statistics provide just one facet of *Dai*s' work and exclude the rich lived experiences that are vital in the understanding of human interactions. Certainly numbers would not have captured the *Dai*'s conception of the placenta and the umbilical cord as *Vishnu* and the nine-headed snake. What would have occurred is that this *Dai* would have been categorised as an illiterate, another statistic, instead of taking into account her indigenous knowledge and explanation of events.

The participants' views about *Dai*s affect their association with them. In addition, the data show that perceptions are influenced by how *Dai*s meet the needs of the participants. One example is the common refrain that *Dai*s are good women; they do good work. But how *good* is defined and what measurements or values are used to measure goodness or denote a good individual differ from one group to another. Being identified with social markers such as *poonya ka kaam* and *dharm* is desirable. *Dai*s and those around them perpetuate these identifiers, first, to enhance the *Dai*s' position and, second, to ensure that delivery work is accessible.

Other factors that influence the multiple views about *Dai*s' work are linked to the cultural interpretation of delivery. In the South Asian worldview, delivery work connotes ritual pollution from various bodily fluids. Some *Dai*s have indicated that if they had any choice, they would rather do other work instead of being birth attendants. They engage in this type of work out of necessity when they feel that there are no other alternatives available to them. They see no direct benefits from being engaged in delivery work financially or socially. There is a paradox in this view. The fact that some of them are able to work as birth attendants even when they do not have formal training, relying on the experiences of their own childbirth, shows that delivery work does provide them with an alternative. Clients also noted that the presence of *Dai*s provides them not only with alternatives to their limited financial situation, but also a choice in the management of childbirth. Clients and villagers observed that without this choice, many families would be burdened financially or unable to access basic delivery services. Thus it seems that not only do the concepts of alternatives and choices apply to *Dai*s, but they are also equally important to the *Dai*s' clients.

The second paradox is found in their ambivalent feelings towards delivery work. Although *Dai*s noted that this activity accords them the social prestige, what is said indirectly is that they would prefer to earn their social remuneration (*poonya ka kaam* and *dharm*) through a different route. The interesting point is that *Dai*s juxtapose their feelings of satisfaction and dissatisfaction about delivery work without being aware of the paradox.

*Dai*s and other interviewees saw the current remuneration rate by the state government as inadequate. The rural *Dai*s do not consider this amount a true reflection of their efforts. The urban *Dai*s, on the other hand, are not paid the nominal fees that the rural birth attendants receive. According to the *Dai*s, the absence of a proper rate of remuneration results in low valuation of their work by the government functionaries. Both SEWA and non-SEWA *Dai*s feel that one of the ways that this could be remedied is through training. Another way is being provided with instruments that biomedical practitioners use to assist in their work. Both strategies are symbols of the dominant establishment. Their assumption is that it would enable them to increase their scope of practice and the value of their work. Furthermore, adopting the symbols of the dominant group would accord them prestige and respect. This view is reinforced by the government, SEWA, and health care practitioners. But the underlying goal of each group and how each attempts to promote this perception differ.

The literature on *Dai*s' work usually focussed on the biomedical training that they receive. However, the literature do not report the constraints under which *Dai*s work and the narrow socioeconomic environment in which their clients live. Yet such conditions continue to be found, as my research data show. Although *Dai*s continue certain harmful practices, these must be contextualised within the evolving Gujarat health care system and the precarious socioeconomic environment. It was found that often *Dai*s had no choice but to resort to those practices. So far the onus had been placed on *Dai*s to influence community members regarding family planning and accessing maternal health care. *Dai*s have been blamed as contributors of high IMR or MMR. Despite the various primary health care initiatives, including *Dai* training, India's IMR remains stagnant.[182] This indicates that there may be other contributing factors that lead to this high IMR and MMR.

In the next chapter I discuss the significance of the issues emerging from the multiple perceptions of *Dai*s' work and their effect on the health of the *Dai*s. In particular, I want to show that perceptions are important in influencing opinions. Individuals who are in powerful positions influence and shape public opinions; this has nothing to do with the correctness of the opinions. It is the ability to convince others that their perceptions are the only valid and correct ones.[183]

I will focus on three issues that have emerged from the findings. They are:

- Gujarat's interpretation of RCH may not support *Dais*' work.
- Work is a socially constructed phenomenon.
- Capacity building is an integral component in the valuation of work.

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[182] When the 2001 census was collected, it was found that the IMR remained constant through 1991 to 2001. There has not been the significant decrease in the IMR that the GOI and GOG were hoping to achieve. A workshop titled National Workshop in Infant Mortality in India: Levels, Trends, and Interventions was held on April 11-12, 2002, in New Delhi to address this issue (www.censusindia.net). Participants included government functionaries (central and states), health officers, researchers, and members of NGOs.

[183] Brigitte Jordan (1993) identified this ability as authoritative knowledge; that is, how a group of individuals convince those around them that their knowledge and skills are the only legitimate way and that following their knowledge would have favourable results. I use the same definition, but in the context of perceptions of work.

CHAPTER 8

DISCUSSION: *DAIS*' WORK AND THE ROLE OF AUTHORITATIVE PERCEPTIONS

Introduction

In Chapter 7, I present the multiple perceptions of participants who come into contact with the *Dais*. In this chapter I discuss the significance of those perceptions and how they affect the work and health of the indigenous midwives of Gujarat. This approach presents a new way of exploring *Dais*' work. As noted in Chapter 1, the literature about *Dais*' work has focussed on both their practice and their training, and to a lesser extent on their economic status, without considering other factors that affect their work. Indeed, one of the criticisms levelled against social science research is that it has often confined its investigations to a single level of social organisation (van der Geest, Speckman, & Streefland, 1990). Many studies consisted of one-sided perspectives, limiting the understanding of social hierarchy in local communities (van der Geest et al., 1990).

A multiple-perspective approach is useful because it shows that competing perceptions are found despite the emergence of authoritative voice(s). Competing perceptions reflect many realities; however, it appears that only one perception sets the tone for all realities. This is key in understanding women's work because it is often perceived as a homogeneous entity. This monolithic term hides women's varied work experiences both within and outside their homes, masks their socioeconomic differences, conceals the power hierarchy among women, and obscures the complex nature of women's work. The lack of differentiation has implications for women's work in regards to policy implementation and the way that their contributions are perceived in various spheres.

The central theme throughout this chapter is the effects of authoritative voice(s) and its attempts to define *Dais* and their work. Multiple voices compete to define *Dais*' work; however, the degree of representation varies. Because of this, certain health policies and frameworks that appear equitable have an adverse influence on *Dais*. This dissonance reveals the limitations of the health frameworks such as WHO's (1978) *Health for All* (HFA) and UNFPA's (1994)

Reproductive and Child Health (RCH) and concepts related to community participation. Equally important is the observation that there are inconsistencies between the Gujarat government's goals of ensuring safe motherhood and its interpretation and implementation of the above health frameworks. In all of these, *Dai*s' voices are missing. Furthermore, this inconsistency has ramifications on *Dai*s' work because it continues to exclude them from the formal health care system. The inconsistent nature also does not fit well with the government's vision of improving women's socioeconomic and political status.

The second important theme of this chapter is the role of authoritative voice(s) in defining work. The common definition of work is that it is an economic activity in which supply and demand form its basic building blocks. However, an economic framework often masks the social construct of work. Although the monetary value attached to a particular work reflects its prestige, this chapter shows that authoritative voice(s) is an important factor that impacts the value of work. Exploring work as a social phenomenon is a step forward to understanding women's work in the same way that increased understanding of health occurs when one goes beyond the biomedical framework. For *Dai*s, this move to contextualise their work as a social phenomenon is important because it becomes clear why their work is devalued, hidden, and labelled as informal work. The social construct framework brings forth the complexity and the contradictions found in women's work.

Perception is the social lens used to understand *Dai*s' work. On its own, perception, like knowledge, is neutral; however, how it is used to promote a particular point of view is critical. This is because perception becomes associated with values based on certain belief system, and depending on the actors, perception(s) can be promoted as authoritative. Thus the significant point throughout this chapter is that authoritative voice(s) does not necessarily indicate consensus, but rather it is a voice(s) that predominates. This is seen at the international, national, and local levels.

Authoritative Perception

Perceptions play a central role in influencing opinions. Understanding this is key in gaining insights into *Dai*s' work. An important point that has emerged is the role of authoritative perception. Similar to Jordan's (1993) description of authoritative knowledge, authoritative perception is the result of how individuals convince others that their perceptions reflect the reality of all. Linked to authoritative perception is the issue of correctness. If we accept the reasoning that multiple perceptions are the result of individuals' varied realities based on their particular experiences, then all perceptions are correct. However, this point is not considered in the conceptualisation of authoritative perception. Indeed, the dominant perception exerts its authority by using its own logic to indicate that other realities are faulty. Therefore, the correctness of the authoritative perception is not questioned, and alternative perceptions become subsumed into an authoritative framework that convinces others that it is *the* correct version of reality. Once this point is established, it becomes easier to implement other strategies that may not be advantageous but are accepted because everyone is convinced of their correctness and benefits. Either questioning the negative effects of authoritative perception or pointing out its faulty logic becomes difficult.

At the centre of authoritative perception is power. Those who put forward their authoritative perception are usually individuals who have the power and the wherewithal to support those views. Any change or challenge is usually met with resistance. Indeed, even those who are negatively affected by the authoritative perception may oppose the challenge. One reason could be the fear of change itself and the comfort of the status quo. Another reason could be that the effect of change is long term and not short term. Last but not least, resistance to change could occur when individuals perceive that new changes are less beneficial than is their present situation. Either way, it is safe to conclude that authoritative perception encourages the status quo. In addition, the link between power and authoritative perception means that the latter is accepted even when it is inequitable. The interesting point is that the outcome of the authoritative perception further reinforces the power of those who are already in positions of authority. Therefore, authoritative perception gives rise to cyclical process and response.

Once the concept of authoritative perception is understood, it becomes clear why health policies and initiatives that are not advantageous are presented as such and adopted. This point is fundamental in comprehending why certain opinions prevail over others and why certain images remain unchanged despite efforts to the contrary. It provides the basis for understanding why, after 25 years, HFA is still considered to be the practical route to addressing the health shortage and why India and Gujarat recently adopted the RCH framework. Authoritative perception was used in the successful implementation of HFA and in the promotion of the RCH framework. Policymakers from international, national, and state levels have convinced the Indian public and other stakeholders of the validity of the frameworks which, when implemented, would provide accessible and appropriate health care to the public and empower the marginalised. Therefore perceptions matter, and to ensure that the views are accepted, they are presented as authoritative. Authoritative perception explains SEWA's success and its ability to implement groundbreaking initiatives even though the results may not be visible in the short term but become apparent in the long term and the work difficult. The organisation has positioned itself as an authoritative voice of its members.

Health for All: Establishing its Authoritative Perception

Two factors contribute to the authoritative position of the HFA framework. First, the framework shows that achieving good health does not require a complicated health care structure; nor does its implementation require a sophisticated technological base. And to avoid strain on the limited resources, the HFA encourages policymakers to use appropriate technology, including existing human resources. The strength of the framework is therefore rooted in its simplicity. The second reason for its authority is its generalisability, which implies that the framework is applicable in multiple settings, thus reinforcing the perception that it is correct. Together, they have promoted the validity of primary health care. Despite the obvious advantages, my findings show that the involvement of the *Dai*s within the HFA framework has not benefited them. Instead, I will argue that their work is further informalised under community participation. Community participation provides a convenient label for the Gujarat government to exclude them from the formal health care system and thus avoid paying them regular income.

The way the HFA framework had been integrated within the Gujarat health care system also comes into question when multiple perceptions of stakeholders (Gujarat health officials, health care workers, women, villagers, and *Dai*s) are juxtaposed. Although the above individuals are referring to the same health care structure, where they differ is their individual perception of how the system is meeting their needs or the needs of the population. Their multiple perceptions compete to tell a different story about the HFA; however, only the authoritative perception has emerged—the top-down view of what the HFA *should be* versus the bottom-up view of what the outcome of HFA *has been*. Indeed, the authoritative voices of the HFA and its implementers are so deeply entrenched that questioning its correctness is difficult.

Health for All and the Significant Lessons Learned

Despite the lofty goal of HFA, much of the literature provided examples that show that the original intent of the HFA has not been fully achieved (Justice, 1987; Matomora, 1989; Morgan, 1990; Nichter, 1986; Rifkin, 1986; Rifkin & Walt, 1986; Smith-Nonini, 1997; Stone, 1986; Ugalde, 1985; van der Geest et al., 1990; Werner, 1981; Woelk, 1992). According to the literature, those who urgently need health services continue to be without them or are coping with poor or nonexistent services, a point that has also emerged in my study as villagers told of their struggles to access affordable health care in rural Gujarat. Many of them travel to cities or go to private physicians for treatment because the primary health centres or the subcentres in their villages or nearby are either closed or ill-equipped. Some buildings remain incomplete due to lack of funds, and others are in disrepair. It is safe to say that, on paper, it would appear that citizens have access to health services; in reality, accessible, affordable, and appropriate health care is not available to most people in rural Gujarat. Various authors noted that, in part, this is a result of a top-down decision-making process by politicians, members of the biomedical establishment, and international funding agencies based on their own perceptions of what is required rather than what is actually needed. According to Nichter:

> The distributional and equity aims inherent in PHC are often paid lip service while programs implemented in the name of PHC are accommodated to local power structures and health bureaucracies which are socially, administratively, and politically self-sustaining. (1986, p. 347)

Van der Geest et al. (1990) made the same observation:

> By officially including PHC in government policy, by training people, by setting up programmes and providing resources, the state has incorporated PHC into the existing health care system. . . . In most cases it is still organised from the top and carried out by professional workers from the state, with the help of outside finances. (p. 1028)

Using a multilevel-perspective approach, the authors noted that meanings of similar concepts and ideas change as they move from one level to another while retaining the same labels (van der Geest et al., 1990). For example, Rifkin (1986) showed that community health meant different things to different groups. To the planners, community health meant health care provided *by* the people, whereas to community members it usually meant health care *for* the people (p. 161). According to van der Geest et al., the multiple interpretations of HFA and its concepts have led to intense competition among stakeholders instead of co-operation. Using the example of community participation in the HFA, Woelk (1992) further noted that "varying interpretations of community participation also represent a culture of these different groups. There is after all a culture of professionalization, bureaucratization, and of power" (p. 421). Nichter (1986) contended that there needs to be devolution of power and decentralisation of governmental bureaucracy before the original spirit of the HFA framework and active citizens' participation can occur. He stated, "Community health workers are typically incorporated into a health infrastructure, and ultimately made responsible to the health bureaucracy and not the communities they are to serve. Community representatives are asked to facilitate compliance to predetermined programs" (p. 347).

Ugalde (1985) noted that the success of implementing HFA, and in particular its community participation portion, is inversely correlated to the degree of social and income stratification. This is because in a highly stratified society, equity and social justice become neglected, and there is no interest in improving the quality of service for the poor (Ugalde, 1985). To Rifkin and Walt (1986), health care is more than a service delivery; rather, it is related to broader socioeconomic and environmental issues. They pointed out that because equity is one of the key pillars of HFA, there needs to be a greater effort on behalf of governments to ensure the removal of inequitable policies that reduce access on the part of those who need the service.

One such initiative of the HFA had been to promote community participation. The other was to encourage increased involvement of indigenous healers. But Werner (1981) pointed out that in Latin America, "there was usually a minimum of effective community involvement and a maximum of dependency-creating hand-outs, paternalism and superimposed, initiative-destroying norms" (p. 47). He was also critical of the way the work of indigenous midwives is monitored and the limitations placed on the work of village health workers. He attributed this to

> safeguarding the medical profession's monopoly of curative medicine by using the standard argument that prevention is more important than cure; . . . instructors often taught these health workers fewer medical skills than many villagers had already

> mastered for themselves. This sometimes so reduced the people's respect for their health worker that they became less effective, even in preventive measures. (p. 48)

Van der Geest et al. (1990) and Pillsbury (1982) noted that the HFA's call for integration and co-operation between biomedical health workers and indigenous healers has not been fully realised. Lip service had been given to the whole idea, and, in reality, there had been no real collaboration between these practitioners. In fact, they observed that health care workers are generally opposed to forming a close association with indigenous healers because they do not perceive it as beneficial. On the other hand, indigenous healers are keen to establish linkages because of potential prestige and increased income (Pillsbury, 1982; van der Geest et al., 1990).

Summing up, the recurring point throughout the post-HFA literature is that translating the idealistic goals of the HFA framework into a working model was (and continues to be) an uphill task. Reasons include unequal relationships among different players, conflicting interests, and multiple interpretations about health and what needs to be done. According to Smith-Nonini (1997):

> Supporters of comprehensive PHC in the Alma-Ata years underestimated the degree to which professionals, politicians, and development agencies had vested interests in curative care. . . . Further, there are few immediately visible gains from preventive efforts, and most politicians, development agencies (and, poor people themselves) like to see visible, preferably measurable, results in a few months or years, not decades. Thus preventive health has remained the unprestigious, underfunded step-child of curative medicine. (p. 368)

Within this context it is not difficult to understand why the co-operation between indigenous and biomedical health workers had been difficult. Indigenous and other community health workers often do preventive health work, usually using low-level technology, whereas biomedical workers do curative management that traditionally has been associated with high-end technology, a situation also found in Gujarat. At the outset the relationship between *Dai*s and biomedical health workers appears cordial, but philosophical differences regarding the management of childbirth, delivery and pregnancy mean that the relationship is often strained. Co-operation between *Dai*s and biomedical health workers is usually predicated on personal relationship rather than the latter's respect for *Dai*s. *Dai*s manage their delivery cases using either the simple DDK or indigenous materials, techniques, and knowledge. The low technological base has led to the perception that the *Dai*s' expertise is backward and their procedures incorrect. Together, they devalue *Dai*s' work and further support the idea that, in the long run, *Dai*s' contributions may be unnecessary. These perceptions also reinforce the unequal relationship between *Dai*s and the biomedical health workers because it appears that the opinions of the dominant group have prevailed. Thus the development of human resources, central to the HFA, remains elusive because those in the margins continue to be excluded from real power sharing.

Gujarat and *Health for All*: Understanding the *Dai*s' Position

The collaboration between indigenous and biomedical health workers as envisioned by the HFA formulators appears to be tenuous in Gujarat because the government's authoritative perceptions about *Dai*s and their work have not changed. The way the Gujarat government has tried to engage *Dai*s appears to be inconsistent with its overall goal of providing accessible maternal care: *Dai*s are provided with training and DDKs but, at the same time, are informed that their services may be redundant. The concept of authoritative perception is useful in this context because it brings to the forefront the idea of work as more than a physical effort. Work is a social construct that allows those in power not only to determine its value (economically, politically, and socially) and its direction, but also to control those who are performing the work. Using its authoritative position, the Gujarat government continues to set the agenda for health care, including who will have a role and the nature of this role.

In India the implementation of HFA and the co-operation between *Dai*s and biomedical workers have been complicated by the social and structural hierarchies found in its health services and among its providers. Health centre workers are aware of each other's status, reinforced by salary, knowledge, and access to power and symbols of power (Nichter, 1986). In addition, caste intensifies issues of power, status, and knowledge in India. Nichter observed:

> One of the most fundamental issues challenging the implementation, and thus viability of the primary health care concept (PHC), [HFA] in the developing world, is whether an essentially democratic concept can be operationalised within countries having complex hierarchical social structures. While the path of PHC rhetoric is inspirational, the path of PHC operationalisation is commonly that of the least sociopolitical resistance. . . . This results in a glossed continuation of the previous policy in which health service is a commodity delivered by health professionals and their assistants. (p. 347)

As noted in Chapter 3, India's adoption of HFA appeared to be seamless because of its existing decentralised health infrastructure and programmes. Although India concentrated its resources on ensuring that its population enjoyed basic health care, its mainstay was family planning to control population growth. The target-setting approach continued as India embraced the framework of primary health care. Health care workers at the primary level focussed on meeting the targets set at the central and state levels. At the outset there seems to be a conflict between the HFA's community participation based on a community's needs and government's health planning and target setting. The target-setting family planning and other focussed health programmes indicated that the needs of the community were identified by top health officials rather than the people themselves, which is what the HFA was promoting. As van der Geest et al. (1990) observed, the "interests of the peasants and urban poor with regard to children differ fundamentally from the views of government leaders, which are tuned towards national economy and political stability" (p. 1033). This mismatch highlights the centrality of authoritative perception. Despite the dissonance between people's values and the government's interpretations of those values, it is the latter's authoritative perception that has prevailed to influence the overall health policies of India. It appears that the Government of India was able to convince the public of the correctness of its move to align community needs with the national development (greater good for a greater number of people to attain prosperity) framework in order to move forward. And because health is a national initiative, the Gujarat government followed the GOI's lead.

In addition to meeting targets and promoting various family-planning methods, health care workers were also expected to carry out multiple types of health work, including curative, preventative and educational. This placed an enormous burden on them to complete their work and submit their reports to avoid adverse effect (Nichter, 1986). My findings in Gujarat support Nichter's observation. The health workers in Gujarat voiced similar frustrations about their workload and the lack of satisfaction they derived from their work. To cope with their heavy workload, they concentrated on achieving the minimum and focussed on curative medicine instead of understanding socioeconomic factors or formulating long-term solutions with villagers. For some, this was just a temporary posting until they either found a better position in the city or could operate their own private clinics. For example, the medical officer MOm took up his rural posting to fulfil his bond requirements. He would leave for the city to work in an urban hospital once his two years were completed. MOj on the other hand, 'volunteers' his time in a cardiac unit at a large general hospital in preparation for his transfer when it is approved. His reasons for requesting a transfer: There were no colleges for his children, and he experienced reduced financial rewards. A reduced chance for promotion is another reason why health personnel (all levels) are reluctant to be posted to the rural areas.[184] Because of this, the Gujarat government continues to face high staff turnover, and many posts remain vacant. Within this environment, *Dai*s of Gujarat play a strategic role because they are accessible (financially, culturally, and geographically) to people and continue to meet the needs of the overburdened health care system. However, the authoritative views of the GOG appear to downplay the gap in the health care system and *Dai*s' role.

Although *Dai*s have been (and continue to be) an integral part of the community's healing network, their inclusion in India's formal health care system was based on the latter's need. The HFA framework has further legitimised *Dai*s' inclusion. Although my study and those of others show that indigenous midwives are essential, they continue to remain on the periphery. This is because the official perception of *Dai*s' work has gained legitimacy over that of community members, who indicate that *Dai*s' work is needed for the well-being of pregnant women. At the outset there appears to be no contradiction in the way the Gujarat government has gone about engaging *Dai*s. To show that it is sensitive to people's needs by including *Dai*s and to deflect criticisms that it is not doing enough, the government has skilfully integrated the perceptions of the community about *Dai*s to engage them in the formal health care system. At the same time, the government has used its own authoritative perceptions to shape a health care framework that appears to exclude *Dai*s. A careful examination shows this paradox, but this fact remains hidden because the authoritative views of the GOG have presented it otherwise.

There are various reasons why *Dai*s are involved in formal health care in Gujarat. Government officials saw the potential benefits of involving *Dai*s in their health work, especially in family planning. Because they are from the community, it was thought that they would be more effective agents of change because people would be more receptive to their messages. Health care workers welcomed *Dai*s' inclusion because they assumed some of the health responsibilities and lightened their workload. In this regard, *Dai*s became informal health workers and facilitated the government's health initiatives without establishing any formal framework to influence the direction of this relationship. The collaboration envisioned by the formulators of HFA had been co-opted because *Dai*s are not independent practitioners in the system but come under the supervision of health care workers. This is clearly illustrated in the manner in which DDKs are distributed and the payment of nominal fees to rural *Dai*s in Gujarat.

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[184] Even within rural postings, there are certain districts, *talukas*, and villages that are considered to be of premium value compared to others, so the demand to be posted to these areas remains high.

The idea behind the DDKs was to ensure that *Dai*s had the basic implements to assist them in their delivery work. However, distribution of the DDKs is controlled by primary health care staff, which allows them to monitor *Dai*s' work. When a female health worker (FHW) learns of a delivery conducted by a *Dai* in her area, one of the first things that she does is to visit the mother and infant. The FHW checks the baby, examines the umbilical cord, and questions the mother and other family members present during the birth to learn how the *Dai* conducted the delivery. In doing so, the FHW is able to ascertain whether the *Dai* used the DDK during the delivery and whether she followed the 5-Cs.

Replacement of DDKs is another way in which *Dai*s' work is monitored. *Dai*s are asked to account to the FHWs/FHSs for the DDKs they have used, and the health staff then compare this with the number of deliveries conducted by *Dai*s. Although government health officials may justify their attempts to monitor (i.e., to reduce IMR and MMR), there are other implications. There is a potential for this monitoring to further deepen the distrust between *Dai*s and biomedical health workers and officials. Nichter (1986) observed that distrust between the FHWs and public health nurses in India has affected the level of care rendered. There is also a potential for it to affect the community's confidence in *Dai*s, which could lead to unfortunate results for both clients (especially for those who are poor) and *Dai*s. Because many *Dai*s are from low-income strata, the lack of trust may affect their source and level of income. The end results would be loss of income, increased poverty, and a negative impact on health. Therefore, it seems that, at least in Gujarat, the co-operation and collaboration between biomedical and indigenous health workers appear to be unequal. In fact, they have transformed into hierarchy and monitoring that could have negative ramifications for *Dai*s' work and health. Furthermore, it could be said that control of *Dai*s' work is the result of the low value placed on women's work, especially domestic work. In addition, *Dai*s' mode of learning means that their knowledge and expertise are identified with the domestic sphere, which legitimises the Gujarat government's attempts to monitor their practice. The control could be based on the assumption that *Dai*s' skills and knowledge do not meet the biomedical standard. The control affects the tenuous trust between health officials and *Dai*s and accentuates the unequal power that allows the former to determine the boundary and status of the latter.

A *Dai* qualifies for the nominal fees *only* if she is trained, registers the woman with the primary health centre, and takes the woman for her various immunisations, supplements, and health check-ups. The Rs. 20 that rural *Dai*s receive are not payments for their work per se, although *Dai*s regard them as critical economic support. In fact, it is not a true reflection of the value of their work, and *Dai*s have attested to this. Instead, the nominal fee is to encourage safe births (through the above actions) and to ensure that women access health services through *Dai*s. It appears that the Gujarat government has succeeded in involving *Dai*s in performing biomedical work similar to that of FHWs and, at the same time, easing the workload of these workers. The registration of prenatal cases further assists health care workers to maintain accurate statistics. On the other hand, the eligibility criteria for the nominal fee could also be interpreted as another avenue for the biomedical establishment to supervise *Dai*s and influence their work. It is uncertain whether the Gujarat government intended this, but what it does indicate is that health care workers are in a better position to evaluate and influence *Dai*s' practice. Another observation about the nominal fee is that it appears to emphasise the social, knowledge, and economic hierarchies and differences found between the biomedical health workers and *Dai*s, a point that was not lost on either group, as the findings of my study show.

Although it seems that the nominal fee creates a win-win situation, my findings show that it has an unintended negative effect on *Dai*s' income. Stephens (1992) also found this to be the case in her study in Andhra Pradesh. According to *Dai*s, clients perceive the fee as a regular salary or payments from the government to reimburse *Dai*s for their work. However, clients may not be aware that the amount is inadequate to meet *Dai*s' needs, and payment is often irregular. Clients' perceptions about the fees have led to a misunderstanding where they either refuse to pay *Dai*s or underpay them, seriously affecting *Dai*s' already precarious source and level of income. There is also a potential for negative social ramification if *Dai*s insist on some form of compensation from the clients. *Dai*s could be perceived either as unsympathetic to clients' socioeconomic plight or as greedy. In a society in which reciprocity is key to daily living, these negative ramifications could have a profound impact on the physical and mental well-being of *Dai*s and their families. They could be shunned or ostracised by their community members. To avert this negative social impact, the Gujarat government could address this issue in three ways: (a) by ensuring a greater transparency about mode of payment and its amount; (b) by increasing the amount to reflect the actual value of *Dai*s' work so that *Dai*s are not entirely dependent on clients for income, thereby removing the burden of payment from those who cannot pay; and (c) by ensuring that payments are regular, thus reducing the uncertainty and stress of irregular income. Indeed, the second and third solutions have been suggested by both health care workers and *Dai*s.

Throughout the world indigenous midwives found themselves inducted into the formal health care system through government (and, at times, NGO-sponsored) training programmes when countries were adopting the HFA framework. This is true for *Dai*s in Gujarat. The goal of training was to change their former practice based on the belief that *Dai*s were backward and contributed to the high IMR and MMR. Whether or not this was the case, because there had been no formal studies done in Gujarat, this view nevertheless provided the entry point for government health planners and international funding agencies to intersect and influence *Dai*s' work, a point that both Justice (1987) and Ugalde (1985) noted in their own studies. In fact, Mavalankar (1999) alluded to other causes of MMR that indicate that *Dai*s may not be the main contributors. What is important to note is that the persistence of 'old' practices by *Dai*s is not as clear-cut a case as both the literature and the Gujarat health officials/health workers (such as MOm and FHWn1) have claimed. The testimony of the rural *Dai* tells of the constraints under which *Dai*s work and the difficult situations they face. Not examining the reasons that *Dai*s continue with their practices (despite the health training) means that factors that place *Dai*s in difficult situations may not be corrected for a while. Another point that has not been considered is that *Dai*s, like all healers, have an ethical responsibility towards clients and their families. Just like biomedical health workers, *Dai*s have to make quick decisions to assist women and their infants, and this could mean that at times they may have to make do with the bare essentials and not follow the 5-Cs.

Similar to biomedical health workers' 'unsafe practices' under extenuating circumstances are protected under the notion of 'Good Samaritan'; understanding *Dai*s' difficult circumstances would ensure that they too are accorded the same immunity and not punished for something over which they may have no control. The potential advantages of this move could lead to increased trust between biomedical health workers/officials and *Dai*s and a greater co-operation in addressing factors that contribute to unsafe practices. But unless the authoritative perception that projects *Dai*s as backward and resistant to new ideas and knowledge is removed, the barrier towards co-operation will remain because of lack of trust. However, certain assumptions could be made to explain why these authoritative perceptions persist. It could be that they serve the power base of health officials and legitimise the initiatives to influence *Dai*s' work. Revising these authoritative perceptions could mean acknowledging that other factors that impact *Dai*s' work have not been taken into consideration when initiatives were formulated. The ramification of this admission is wide ranging because it could lead to questioning of other decisions deemed correct.

The WHO (1978, 1992) stated that indigenous midwives are usually of high social standing and exert considerable influence. Although this observation may apply to midwives in other parts of the world, it does not apply to *Dai*s in Gujarat. *Dai*s are not authoritative, nor do they have high social standing. Their socioeconomic position is similar to that of midwives in other parts of India. Even when the WHO's reference to high status points to midwives' informal position as essential members of the community instead of their formal health/sociocultural affiliations, *Dai*s of Gujarat still do not have high status. This is because the nature of midwifery work itself has connotations of untouchability and pollution. Furthermore, *Dai*s lack the political power to push for changes to benefit them financially and socially. The statement made by the senior health officer (HIASCGuj1) that *Dai*s would not receive attention if it were not for the efforts of government and NGOs reveals *Dai*s' marginal position within the current health care structure. It could also imply that if *Dai*s were held in high esteem, they would not require endorsements to highlight their work. His statement further provides valuable insight into *Dai*s' future in Gujarat's RCH-based health care. It gives rise to important questions regarding the nature of *Dai*s' role in the ongoing health reforms. The senior health officer's statement may not reflect Gujarat government's overall vision of *Dai*s; nonetheless, his views could indicate the sentiments of those who are in a position to influence the formulation of health policies. The emergence of multiple authoritative perceptions competing to define *Dai*s' work is important because not all authoritative perceptions are influential.

What lessons may be drawn from the discussion so far? One lesson is that there is a possibility that *Dai*s' economic, social, and political positions may not see significant, tangible shifts under the Reproductive and Child Health (RCH) framework. This possibility is based on the Gujarat government's previous health policies under the HFA regarding *Dai*s and its interaction with them. I also base my tentative observation on statements made by health officials. The second lesson is that valuation of work is dependent on whether it comes under the purview of work (that is, paid work) or whether it is considered nonwork and is therefore unpaid. When one observes how the work of FHWs and *Dai*s is valued (monetarily and socially), it becomes clear that work/nonwork are essentially social constructs. This has important implications for *Dai*s in the context of RCH because how *Dai*s and those around them define *Dai*s' work will determine future income and political voice.

Gujarat's Interpretation of RCH May Not Support *Dai*s' Work

Under the HFA framework (WHO, 1978), *Dai*s in Gujarat have experienced some financial and social gains. Over the years the Government of Gujarat has put into place various schemes to recognise *Dai*s' contributions. Indeed, the increase in the nominal fee rate, the training sessions, the issuance of identity cards (IDs), and the distribution of DDKs are some ways that the state government has attempted to address *Dai*s' socioeconomic concerns. But despite these innovative schemes, *Dai*s have not experienced significant tangible changes in their lives and work. Their economic uncertainties, political marginalisation, and social stigmatisation remain. In part, this can be attributed to the unchanging mindset about *Dai*s and their work. The Gujarat government itself continues to adhere to and reinforce old images about *Dai*s and their work, which contradicts its objectives for the initiatives. The persistence of outdated authoritative perceptions means a chasm exists about *Dai*s' valuable work and masks the constraints under which they work. The fixed mindset leads to wider gaps in perceptions about the changing nature of women's work; in this case, the changing environment that *Dai*s face regarding their work. In sum, the static perception of *Dai*s appears to ignore their aspirations and stifle their capacity to define their work and who they are.

Another reason is that although the HFA framework has encouraged co-operation between various health workers, the nature of this co-operation and integration is vague and left to the discretion of respective governments and countries. It is important to note that this co-operation is not based on equal footing (mutual needs and equal partnership), but rather on a dominant system's needs, a situation in which *Dai*s find themselves in Gujarat. The underlying message within its document (WHO, 1992) is that indigenous midwives should be phased out once the formal health care system is able to bridge the gap and health care workers are able to cope with the workload. Again, various health officials in Gujarat also echo this sentiment. The role of gender and its ramifications were not given full attention in any of these documents. Together, they have contributed to the status quo and casualisation of *Dai*s in Gujarat.

The Community Needs Assessment Approach (CNA): Authoritative Perceptions and Contradictions Within

Multiple perceptions compete to explain reality, but it is the authoritative version that is accepted. Both the GOI and GOG rely on their authority to ensure the success of health policies and convince stakeholders of the benefits. In authoritative perception frameworks, contradictions are presented as minor aberrations that do not require in-depth examination because the goal is to bring about changes that would benefit as many individuals as possible. India's interpretation and implementation of the HFA is a case in point. Using the same reasoning, the GOI has adapted the RCH framework to suit its national development goals, one of which is population control. Although adaptation is key to success because policies are tailored to meet the unique needs of the people, the inclusion of population control in the GOI's Community Needs Assessment Approach (CNA) framework shows that former policies continue to take precedence despite the shifting health structure.[185] For *Dai*s, this could mean that previous authoritative perceptions that define their work might persist.

However, the implementation of RCH by India and Gujarat has the potential to impact *Dai*s because there could be a change in resource allocation and in the way women's health and work are defined. The GOI's CNA is a blueprint that will guide health care workers and officials in their work to provide community health services. However, a careful examination of the literature on the CNA framework shows otherwise. The CNA, in fact, reinforces the role of an authoritative perspective to mobilise and convince stakeholders to adopt changes even when the so-called 'changes' are similar to the original policies. Statements such as "maternal and child health care is now being described as reproductive and child health [and] is a very important component of the family welfare programme in the country" (GOI, 1996, p. 2) lends credence to the above observation. The GOI indicated that the CNA reflects its commitment to move away from the target-based approach towards health initiatives directed by the needs of the community. However, it seems that the CNA continues to have a target component. This is clearly illustrated in a document titled *Basic Guide to Reproductive and Child Health Programme: For Use by NGOs, Training Institutions, and Health Functionaries* (GOI, n.d.a). It was noted that when the CNA was initially called the Target Free Approach, health functionaries, especially those who carried out the primary health care in the field, had the impression that

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[185] The Community Needs Assessment Approach was initially called the Target Free Approach (TFA), but the name was changed to the former in 1997. Because I was unable to interview health officials from the central government, I shall base my discussion about perceptions and influence on the GOI's documents.

> **they did not have an obligation to deliver any specific amount of work. This, of course, was totally a wrong perception because the goal of achieving stable population has remained. . . . The intention in giving up the practice of targets was never to slow down the work relating to [the] reduction [of] birth rate.** The Government of India utilized the financial and technical assistance of UNICEF and helped State Governments to retrain health functionaries at all levels for removing any such misconceptions and for orienting them for correctly working under the Target Free policy. (p. 5; emphasis mine)

Another document, *Reproductive and Child Health Programme: Schemes for Implementation* (GOI, 1997c) made the following link between population control and RCH:

> [The] RCH is even more relevant for obtaining the objective of stable population for the country. . . . Therefore, RCH programme by ensuring small families also ensures stable population in the medium and long-term, though in the short-term, population is controlled by use of spacing methods and terminal methods [to avoid] unwanted pregnancies. Therefore, the overall strategy of the Government of India (Department of Family Welfare) is to simultaneously strive for obtaining [sic] Reproductive and Child Health arrangements for the whole of the country's population and to promote and make available contraceptive/terminal methods for couples. (p. 3)

A manual designed to assist health functionaries in carrying out their RCH health work using the CNA approach gave the following instructions:

> Every village visited by the field workers should be made conscious of the increase in the population of that village during the last 50 years and the need for effectively stabilising that population at a level which can be sustained within their own resources. . . . Women usually understand the importance of a small family and they should be suitably motivated to exert social pressure in this regard. Men should be made conscious of their importance as guardians of health of the family. In this context, the simplicity and the importance of vasectomy should be emphasised again and again. (GOI, 1996, p. 2)

The contradiction in the CNA relates to the issue of the target-free approach. Health functionaries are still required to focus on population control even when there is community consultation and it is target free. Their health work continues to be closely circumscribed to control the birth rate. This was evident when health functionaries were "retrained," and "corrective actions" (see below) were instituted to change their beliefs about the target-free approach. In reality, the target-free approach continues to focus on target, the only difference being the shift in the way the target is set. The GOI (n.d.a) noted that "the overall objective [of the RCH] since the beginning has been that the population of the country should be stabilised at a level consistent with the requirement of national development" (p. 9). The reality is that the target approach is very much a feature in India's vision of RCH (CNA).

It appears that even within the CNA framework, women's health in India continues to be defined in terms of maternal health, family planning, and population control, although RCH suggests a broader approach to encompass other socioeconomic factors. The expressed goal of the CNA framework was to ensure that health services are decentralised and client-based, but it was observed that

> **the requirements thus calculated by the ANM [FHW] becomes the target for her for the year.** The CNA manual has specified that if such [a] requirement is worked out carefully, it should increase by about 5-10% over the achieved level of [the] previous year even in well performing states because the requirement will increase every year by a few percentage[s]. . . . As a result of administrative corrective action taken by the state governments and of re-training effort and guidance to field health functionaries in the form of CNA manual the trend of decline in 1996-97 has been reversed and reported figures for sterilisation, IUD insertions, condoms use and oral pill use in 1997-98 have showed a modest overall increase over the level achieved in the previous year. It is expected that such annual increase will become larger as the CNA is understood better by the health functionaries and work at field level is carried out fully in conformity with the policy of CNA. (GOI, n.d.a, p. 5; emphasis mine).

The calculated requirement mentioned above is to be done in consultation with families, women's groups, *aganwadi* workers, and *Panchayats* in the area of contraception and mother and child health. However, it appears that the consultation group does not include the *Dai*s even though they provide delivery care to mothers and infants and promote various family planning methods. Their exclusion illustrates the inherent contradiction within the CNA despite the fact that the GOI has promoted it as inclusive and equitable, modelled after RCH. Documents on the CNA framework (GOI, 1996, 1997b, 1997c; 1998; UNICEF, 1999) indicate that *Dai*s will continue to carry out health work, but whether there would be any change in the scope or whether *Dai*s would play a leadership role in the future of health care remains unclear. However, a logical conclusion based on GOI's CNA literature indicates that, for now, there seem to be no concessions made either to accommodate or to initiate changes in *Dai*s' socioeconomic position. It appears that the status quo will continue even in RCH and that *Dai*s' participation will be one of circumscribed and selective participation. For example, a GOI/UNICEF document suggested that one of the ways to revitalise the subcentres is to strengthen the link between the FHWs and *Dai*s to provide a more integrated health care (UNICEF, 1999). The selective participation also reinforces the belief that those who are in power control the level of involvement. In this case, the power lies in the hands of both the central and the state governments of India, and they determine the social construct and economic boundary of *Dai*s' work. It also highlights the difficulty in implementing policies based on ideals to real-life situations, especially in an environment in which there are multiple hierarchies. The CNA, by not addressing the needs of *Dai*s, appears inequitable. What the CNA does is to project an authoritative perception that in the formal health structure *Dai*s lack value.

An important aspect of RCH that is not found within India's CNA health framework is the link between work and health. Although gender is recognised as an important factor that determines the health of women, there are no provisions made to empower women health workers such as *Dai*s. The attention so far has been population control and providing accessible health care to mother and child. The focus on the latter is understandable because maternal mortality in India accounts for one quarter of the total estimated 600,000 maternal deaths in the world (GOI, 1996). Because India's (and Gujarat's) aim is to embrace RCH as its health framework, there needs to be a more concerted effort to address health beyond women's childbearing and reproductive function and integrate education, employment, skills development, and removal of social, political, and economic inequities that impede women's progress as part of its health work. For now, the actions of the GOI and the GOG bring to mind the assertions made by researchers (Nichter, 1986; van der Geest et al., 1990) that in many instances the implementation of new programmes does not entail an overhaul of the old structure, but is rather a continuation of the same system.

The Weak Link in the Health Care System: Phasing Dais out of Gujarat

Although the GOI stance on *Dai*s appears to be the same as in the previous HFA, my findings show that officials in Gujarat regard the continued dependence on *Dai*s as an indication that the health care system is inadequate. They label *Dai*s' presence as a "*weak link*," a label that not only reinforces *Dai*s' marginal status within Gujarat's health care hierarchy, but also emphasises their informal position. Being known as a weak link negates *Dai*s' important contributions because it minimises their role as health care providers and points to their tenuous identity as bona fide health workers. For example, a weak link neither highlights the savings experienced by the health system when *Dai*s conduct home births, nor acknowledges that *Dai*s' interventions offset the strains on the system mentioned by FHWm1. Thus a weak link does not give a true picture of the extent to which *Dai*s shoulder the burden in ensuring that delivery services are rendered to women where there may be none or they may be inaccessible. When health staff are unavailable after office hours at subcentres or at primary health centres, *Dai*s manage deliveries in the villages and urban areas. Instead of seeing them as an essential link between poor women and the overburdened health care system, the authoritative perception of *Dai*s as a weak link hides the real reasons for *Dai*s' increased responsibilities and involvement.

There appears to be an underlying assumption that *Dai*s, in being described as a weak link, add to the problem of health care. This perception is related to the stereotyped image of *Dai*s and their management of delivery. In holding on to these images, the Gujarat government legitimises its policies of intervention (such as training) and its plan to phase *Dai*s out of the health care system. The government justifies the phasing out of *Dai*s once complete institutional births have been achieved on the assumption that this would provide women with a safer environment. Although the reason may appear to be valid and reflect positively on the efforts of the government, the impact on *Dai*s will be negative. Their income level would decrease drastically as more women turn to biomedical care. *Dai*s would become further marginalised and lose whatever small foothold they have in the formal health care system. The Government of Gujarat's move towards phasing out *Dai*s does not align with the RCH framework. Its actions neither empower *Dai*s nor provide them with opportunities for employment and skills development. Phasing *Dai*s out reflects the low value of women's work and the ease with which it is dispensed when it is perceived as not needed, a fact that was noted both in the *World Survey on the Role of Women in Development* (UN, 1999) and by RSHO when she observed that health officials perceive *Dais* as "*spare parts, excess, spare; when in need, use them; otherwise we have no interest in them.*" The statement illustrates the centrality of power—the power to place the needs of a system over that of *Dai*s and the influence of authoritative perceptions. Together, they lead to blurring of distinct needs of two groups (*Dai*s and the government), the assumption being that all needs lead to one goal or that all needs are similar. Being known as "*spare parts*" or phasing them out neither indicates that *Dai*s add value to Gujarat's health care nor addresses their concerns.

The exclusion of *Dai*s from the formal health system shows that, in reality, the Gujarat government does not perceive *Dai*s as key players or their contributions as significant. Compared to the views of those who provide primary health care at the ground level, the health officials' evaluation of *Dai*s' contributions/role indicates a dissonance between the two views, which could have a negative effect on these workers. With the high staff turnover, heavy workload, and an infrastructure that desperately needs to be upgraded, staff welcome *Dais*, although with mixed feelings. So far the Gujarat government's interpretation of RCH (seen in its CNA) is based on strengthening the physical infrastructure and health delivery, with very little emphasis on human resource development. Again this move is understandable in the context of its current health indicators. But this focus misses the point that good health is also linked to an enhanced socioeconomic status of the population. For women, whom the formulators of RCH deemed poorest of the poor, this includes increased involvement at all levels of society to ensure better representation and access to opportunities. However, the government's plans for *Dai*s do not appear to include the above, indicating that they may continue to be marginalised both as women and *Dai*s.

The decision to phase *Dais* out also contradicts the WHO's HFA. Because equity is one of the key pillars of HFA, phasing *Dais* out means that not only are they unable to have equal access to health resources (clients and income), but also clients themselves would have reduced choices as to whom they can go for care. Despite the various constraints, the women that I interviewed acknowledged that they may choose whether to go to a *Dai* or to private or public clinics for delivery services. Having a choice is important, especially in an environment in which the range of choices for poor women is narrow. Indeed, the WHO (1992) noted that women would continue to go to indigenous midwives even if they had access to biomedical health care, because they seek complementary care and because these midwives meet their cultural and spiritual needs. On the other hand, the goal to phase *Dais* out could be that the GOI and GOG interpret equity differently. If this is the case, phasing out *Dais* may not represent a contradiction of HFA but fit with the governments' overall vision of a good health care system. Similar to the broad interpretation of HFA that led to multiple meanings, it could be that the state and central governments' authoritative perception of equity could indicate that health officials want women of Gujarat to have access to biomedical care. This goal is understandable because biomedicine has projected its body of knowledge as correct and authoritative. Regulating *Dais* could indicate that both the state and central governments are trying to ensure that *equity of care* is available to women. Thus there appear to be two versions of equity. From the *Dais*' and clients' point of view, equity means having choices either in accessing care or earning regular income. From the governments' perspective, equity is ensuring that women have access to biomedically managed maternal care instead of home births. The two versions of equity reinforce earlier observations that perceptions presented as authoritative will prevail regardless of whether they are correct or not.

Apart from staffing, the Gujarat government has not been explicit in terms of its framework as to how it can achieve its goal of complete institutional births. Factors such as hospitalisation costs (user fees, subsidy, or a mixture), transportation (including access and reliability), long- and short-term fiscal capability (internal or external funding), and time needed to achieve the above goal are not available. Phasing *Dais* out without putting in place the infrastructure to address health management issues could actually add to the health care costs. It could increase the burden of ill-health because poor women may not be able to afford biomedical care and therefore may be forced to resort to other means of accessing delivery services. Further studies are needed to ensure that removing *Dai*s will not lead to other health and social problems.

Finally, phasing *Dai*s out or identifying them as a weak link contradicts the entire concept of community participation. If we follow the argument that community participation is key in promoting good health and that *Dai*s have the trust and confidence of the community, the exclusion of *Dai*s actually weakens community participation as envisioned by the HFA because phasing out *Dai*s means removing community representatives who understand the local cultural and social nuances and are able to articulate the needs of the community.

It is interesting to note that strategies for enhancing women's income and work security have been given little emphasis in the Community Needs Assessment approach. Neither is there any mention of ways to increase women's involvement at the policy level. These absences are noticeable in the Gujarat government's approach to its RCH implementation. Both the Gujarat government and the Government of India continue to promote the CNA as a correct interpretation of the RCH. They are able to do so because of their authority as governments working for the common good. It appears that when there is a dissonance in the perceptions between health workers and policymakers, it is the vision of the GOI that prevails and corrects the misconceptions regarding the CNA. The frameworks also provide the Gujarat government with the crucial link to connect its state interests and development with the health outcomes of its population. In establishing this link, the state government is able to convince the public and health workers that it is in everyone's interests to support the Indian version of the RCH. By linking health to state interests, the Gujarat government has been able to deflect criticisms levelled against it by SEWA and others who do not perceive the government's vision of RCH as equitable. Thus a dominant and powerful group can present contradicting opinions as logical, authoritative, and correct.

Work: A Socially Constructed Phenomenon

The common perception of work—physical output that leads to monetary rewards—conceals a different facet of work—work as a social phenomenon. In this context, a noneconomic frame of reference such as authoritative perception allows for better understanding of work's social connotations where power, gender, and culture intersect. More important, the social value of work affects individuals' psychological health. On the outset, *Dais* of Gujarat are perceived as birth attendants who provide delivery services—ordinary, everyday, but essential work. Probing deeper through multiple perceptions, however, shows that their work, like other 'women's work,' is complex, multilayered, and gendered. As noted earlier, exploring *Dais*' work as a social phenomenon is a correct move because it gives insights as to why their work is devalued and considered informal.

Bartley et al. (1999) noted that studies in the UK and Australia have shown that individuals who experience job dissatisfaction or have a poor perception of their work experience low self-worth, similar to being unemployed. In addition, they observed that job insecurity gives rise to physical and psychological ill health. Studies done 10 years after the Black Report[186] on socioeconomic inequalities in health continue to link income differentials and social hierarchy to ill health (Davey Smith, Bartley, & Blane, 1990). The literature on work has shown that the criteria that define work/nonwork and paid/unpaid categories are arbitrary. The same work could be paid and unpaid depending on where it is performed, by whom, whether it is accounted for in the mainstream economic system, and its level of supply and demand. Therefore work is a social construct that is closely connected to societal norms and values. In fact, social and economic values are closely linked to one another; however, the degree to which each influences the other varies. Although the work activity by itself may be predictable and objective, the social constructs that determine its intrinsic values are not. According to Tzannatos (1999):

> The sensitivity of what constitutes women's work in the sense that the dichotomy between work and non-work is to a large extent socially constructed. . . . Setting aside statistical effects, significant variation in the female participation rates arises from the interplay of demographic and social factors and women's family responsibilities. (pp. 554-555)

Thus, the simple label *women's work* encompasses complex meanings of gender and skill (Mohun, 1996). Nowhere is this better illustrated than in women's domestic work, which includes productive and reproductive work. However, the term *domestic work* hides a myriad of activities, skills, and meanings, including the meaning of gender. Domestic skills and knowledge are not given due importance because, more often than not, they are learnt at home as part of the daily activities. However, the same domestic skills acquired in a formal setting attain an economic value because the process of certification legitimises the skills.

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[186] In 1977 the Research Working Group on Inequalities in Health, organised by David Ennal, the Secretary of State for Social Services under the chairmanship of Sir Douglas Black, president of the Royal College of Physicians, published findings in 1980. The central finding of the group showed a link between differential mortality and morbidity rates with various levels of social classes.

Another issue related to the social construct of work is community participation. The literature on community participation in health focussed on the point of view of citizens' involvement in health care (Church & Barker, 1998; Church et al., 2002; Matomora, 1989; Nichter, 1986; Rifkin, 1986; Rifkin, Muller, & Bichmann, 1988; Rifkin & Walt, 1986; Smith-Nonini, 1997; Stone, 1986; Ugalde, 1985; van der Geest et al., 1990; Werner, 1981; Woelk, 1992). Except for Rifkin, who mentioned briefly that "health planners, particularly those working in the Third World, looked to community participation as the way to cope with scarce and unequally distributed resources and with medical domination of health policies" (p. 156), none of the authors identified community participation as a form of informal and unpaid work. Existing literature has examined community participation in the context of empowerment, indicating that this is one avenue for those in the margin to gain a voice and have a role in the decision-making process. However, there is a potential that community participation could be disempowering if it is not followed by other capacity-building strategies.

Dais' Work: A Balancing Act Between the Social and Economic Construct of Work

Dais' work fits into domestic work. Because childbirth in Gujarat is considered part of a woman's life cycle, women learn midwifery informally (seeing and doing) the same way that they learn other household skills classified as "women's work." My findings indicate that *Dais* of Gujarat, like indigenous midwives in other parts of the world, are usually older women who are either married or widowed. Similar to the experiences of other midwives around the world, *Dais* learn midwifery work either from their own female relatives (mother, mother-in-law, sister-in-law, aunts, etc.) or from another midwife in their own village or town through apprenticeships. There are those who acquire midwifery knowledge through their own childbirth experiences, and others have visions or dreams that guide them in their work. Still others are taught by private physicians or by public health nurses at a clinic/hospital where *Dais* live. Whichever way they acquire their skills and knowledge, many *Dai*s come to regard it as an inner or divine calling to work as midwives.

The social construct of work means that the gendered nature of women's work must be considered to understand the conflict that *Dai*s experience as women workers, as skilled workers, and as women from lower castes. Within the Gujarat social framework, *Dai*s' work is perceived as women helping women in the process of childbirth (women's reproductive work). In fact, *Dai*s themselves promote the idea of helping in delivery care and performing good work (*poonya ka kaam*) instead of a paid service. If payment does occur, it is embedded within the social structure of reciprocity or as a token to recognise the gesture of help. What this means is that within the traditional framework of delivery work, *Dai*s are perceived as women fulfilling their duties (*dharm*) instead of as formal health care workers. Indeed, the word *dharm* has a dual meaning, the other being "religion." In the South Asian worldview, linking money with religious work is not something that is deemed desirable. This is not to say that religion prohibits earning income, but the social prestige of being identified as someone who is doing good work and making a sacrifice holds a higher social currency. The disadvantage of this type of 'payment' is that *Dai*s are either paid inadequately or not at all because clients use the notions of *dharm* and *poonya ka kaam* to circumvent payment. Although *Dai*s may gain socially, *dharm* and *poonya ka kaam* do not add economic value to their work. Religious and cultural labels of work do not provide objective guidelines to calculate the actual monetary value of their service. More important, these sociocultural labels fail to enhance *Dai*s' image as skilled midwives.

In a comparison of the steps taken by the Gujarat health ministry with the cultural perception of what is an ideal *Dai,* it seems that two very different systems are operating to define *Dai*s and their work. Proponents of these systems compete with each other to convince outsiders that their perceptions of *Dai*s are authoritative and therefore correct. For example, health officials rooted in the biomedical system consider good maternal management as one which is based on standardised protocols and procedures supported by science. In other words, birthing should occur in a controlled environment. Thus training, issuing ID cards and providing DDKs to *Dai*s are all geared to achieve this controlled environment. These steps could be perceived as moves to elevate *Dai*s' status by presenting them as quasi professionals; nevertheless, the underlying message appears to be that *Dai*s who follow the biomedical protocol to manage deliveries and pregnancies are good *Dai*s. The label "*good Dais*" legitimises the government's control of *Dai*s and deflects any challenge to the correctness of its authoritative perceptions. Because of its power, the government is in a strategic position to constantly shift the boundaries of its authoritative perceptions to create and re-create the image of *Dai*s. The cultural perception of good *Dai*s appears to emphasise their domestic responsibilities. However, these are couched in religious and social terms deemed prestigious, which prevents further questioning about the correctness of these sociocultural values. Similar to control exerted by the government, community members too control *Dai*s' work; however, it seems that their control and power are linked to societal values that even *Dai*s accept despite the negative repercussions on their income. *Dai*s know that challenging the authority of the sociocultural values would impact them negatively. The fear of negative repercussions encourages the status quo.

The disadvantage of *Dai*s' helping role is not limited to clients but extends into the formal health care sector. *Dais*' assistance to health care workers without any formal framework makes it difficult to assess (a) the monetary value of their contributions to Gujarat's health care, (b) the fiscal savings of the Gujarat government in its health expenditures compared to the actual expenditure it would incur if these women did not work and provide their services, (c) the actual market value of the *Dai*s' health services, and (d) the real value of women's work. The lack of data means that at the present time their economic contribution is excluded from Gujarat's overall health care budget, further making *Dais*' work invisible. The implication of invisibility and the unknown costs of helping is that the amount of potential savings accrued by the health care system is unknown. For *Dai*s, it could mean that the goal to bring about a better understanding of the economic value of their work remains elusive.

The lack of concrete data about the economic value of *Dai*s' work or the extent of their contributions means that the Gujarat government's perception that *Dai*s are the "*weak link*," and its move to phase them out will continue unless there are data to challenge the perception. An important point to note is how social constructs could actually shape perceptions of work, including its worth, which may have nothing to do with objective measurements. Thus, "there is a pressing need to challenge the idea that women do not need the same basic employment rights as men because their work is more likely to be part-time, intermittent or home-based" (Elson, 1999, p. 624).

The caste system is a social and economic construct that delineates *Dai*s' work along traditional gender lines. Within this complex system, *Dai*s' work is intricately connected to the culture and the social mode of production of the traditional *jajmani* system. Knowledge, skills, cultural values, and economics surrounding delivery work are passed down from generation to generation, along gender lines. The caste system reinforces the gendered nature of delivery work by assigning it as strictly women's work as part of their domestic duties within the household. Strict social rules (concepts of shame and seclusion regarding sexual matters) that govern the behaviour of men and women further reinforce the division of labour outside and inside the home. In addition, the cultural notion of pollution of afterbirth and untouchability further devalues delivery work, and most *Dai*s have indicated that they engage in this work only when they do not have other choices. Despite the knowledge and expertise required to ensure that childbirth occurs uneventfully, the overarching cultural connotations overshadow the skills of *Dai*s and devalue them as workers. Although *Dai*s' work is necessary, as indicated by clients, health care workers, and villagers, the social underpinning of that work makes it appear undesirable, which affects the income level.

As a social phenomenon, work is a 'cultural tool' that legitimises the power relations between individuals of high and low caste. In Gujarat, women of low caste predominantly do the polluting work and are subject to untouchability. *Dai*s have indicated that despite the stigma attached to their work, they continue to work because it is their *dharm* and they consider their work as *poonya.* Work as a service is something that the majority of indigenous midwives have in common.

*Dai*s are respected and trusted and have the confidence of the community. This was a common observation among participants of my research, and it supports the literature on indigenous midwives. My findings, however, indicate that respect for *Dai*s is neither automatic nor constant. Instead, respect for *Dai*s is predicated on meeting the needs of stakeholders. The observations of the RSHO, MO(Ad), and *Dai* (SAhd7) confirm this. *Dai*s are respected because they are useful. They are accessible and meet the needs of the community. Indeed, in times of need, strict social markers enforced during daily interactions become blurred. However, once the needs are fulfilled, *Dai*s are ignored. Therefore Walt's (1984) call for caution against statements that imply that indigenous midwives are always respected appears to be valid because in the case of *Dai*s in Gujarat, respect is both situational and negotiable.

A key finding that emerged from my research differs from those in the published literature on *Dai*s. It seems that *Dai*s' level of respect, sociocultural status, and income could be enhanced if their usefulness and skills were presented strategically. For example, a *Dai* (SMeh7) was able to negotiate her terms to assist a woman during her delivery. This was because the SMeh7 convinced the client that she would be able to help where others had failed. Furthermore, the *Dai* used her past work record to instil confidence in the woman. It is doubtful whether SMeh7 would have been able to negotiate her terms had she not proved to be a skilled *Dai* or if there had not been an overwhelming need on behalf of the client to have a child that would survive. SMeh7 used her reputation as a skilled birth attendant to remove the barriers that relegated her and her work to a low rung on the social ladder. Because she positioned herself as a key player in the survival of the woman's child, SMeh7 was able to determine the power relations between her and the client. SMeh7 used her skills to gain entry into a previously forbidden social space (the distance observed between high and low caste) to equalise her power with her client. The important point to note is that the *Dai* recognised a need and took the opportunity to highlight the value of her work. In doing so, she showed that the same rules (untouchability, pollution) that devalue her work and marginalise her could be shifted to empower her. It is only by probing deeper that perceptions about the social and cultural interactions that govern *Dai*s's work will shift. The action of SMeh7 is significant because it indicates that if *Dai*s are empowered, they are capable of determining their sociocultural position, and that, in the long run, could change their economic situation. Perhaps this is what the WHO (1992) meant when it observed that indigenous midwives are held in high esteem in society because they perform essential work.

Finally, work as a social construct provides a useful starting point to put forward two alternative interpretations of why *Dai*s experience conflict as skilled workers within the biomedical structure. Previous perceptions of work as service and charity provide a partial answer for the arbitrary binaries such as work/nonwork, paid/unpaid, and skilled/unskilled. The first explanation is that *Dai*s' home-based work and informal learning do not fit with Gujarat's health care system, which uses the medical model as its template for training and delivery care. The medical model, which identifies the process of childbirth as a series of physiological stages and promotes technological interventions as key to safe births (Davis-Floyd, 1992; Jordan, 1978/1993, 1997; Katz Rothman, 1989; Oakley, 1984; Turkel, 1995), contrasts with the indigenous understanding of childbirth as a natural life event and a way of establishing social relations. The comparison of two different systems gives rise to a dissonance where biomedicine's authoritative knowledge prevails over *Dai*s' indigenous skills. Because of its authoritative position, Turkel argued that it has given physicians "the power to control and sometimes to block alternatives to the medical model of birth and, in other cases, to influence the shape alternatives will take and the circumstances under which they will exist" (p. 58). Mohun (1996) noted that the labels *skilled* and *unskilled* are used to reify the hegemonic position of certain groups who are in power. The implication is that alternatives that do not adhere to the authoritative knowledge of biomedicine may not have the space to exist or may lack the professional authority to determine their economic and social boundaries. In Gujarat the hegemonic position of the biomedical establishment, which is supported by the government, seems to marginalise *Dai*s' midwifery skills. Comments such as "*Dais' work is unscientific, and they must be taught to conduct in a systematic and scientific way*" by MO(Ad) and Dr. Vani's "*scavengers and birth attendants*" are indicative of how *Dai*s' work is viewed. These views have provided the government and NGOs with an entry point to intervene in *Dai*s' work to encourage them to adopt biomedicine's protocol for managing deliveries. The conflict arises when the same skills that identify *Dai*s as expert birth attendants are perceived as lacking and harmful by the authoritative biomedical system.

When *Dai*s such as SMeh8 compare their work to that of a doctor or indicate that there is no difference between what they do and what the FHW does, except for outward appearances, they are challenging the government's and the biomedical establishment's authority. SMeh8's observations indicate that *Dai*s are aware that boundaries that delineate their work and that of biomedical health workers are artificial. However, her challenge may not find strong support because society generally accords power to physicians and upholds the perception that biomedical knowledge is superior to that of the *Dai*s. Indeed, NSAhd13's statement "*I asked for Rs. 500, and they refused me. They were willing to give the doctor Rs. 8000, but not the Rs. 500 that I asked*" supports this view.

The second interpretation for *Dai*s' conflict is that they have not learned to market their informal midwifery knowledge as a valuable commodity. According to Elson (1999), "Unpaid caring activities entail work, even though they are not market-oriented" (p. 612). As previously observed, this is related to the cultural underpinnings of doing good work and fulfilling one's duties, on the one hand, and pollution and untouchability, on the other hand. My findings show that for *Dai*s, earning income is not a simple monetary transaction. *Dai*s have to balance their financial needs with their social obligations. *Dai*s' lack of social marketing skills has ramifications for them as workers and for their contributions. Unlike the biomedical establishment, it seems that *Dai*s have not been able to convince the Gujarat government of the savings it accrues from their informal learning or that their midwifery skills are an asset. The government's stance on *Dai*s' informal learning contradicts the RCH decision. The RCH recognises informal learning as key for empowering individuals, whereas the government perceives it as problematic and the cause of adverse health outcomes. Within this context it is logical to assume that the government's move to phase *Dai*s out is because *Dai*s' knowledge, perceptions, and skills about childbirth and delivery do not align with biomedicine. It could also be assumed that *Dai*s' presence poses a direct challenge to the authority of the biomedicine and to the government's goal of complete institutional births, and the GOG uses the notion of a *weak link* to justify its move.

Although the literature portrayed *Dai*s as powerless and unable to adapt, my findings offer a different perspective. *Dai*s are active agents of change even though they occupy a marginal position. *Dai*s are beginning to understand the importance of either identifying with or adopting the various symbols associated with biomedicine to enhance their practise and position.

The Reality Behind Community Participation:

Dais' Informal and Unpaid Work

Apart from the cultural understanding, work as a social construct provides an alternative route to explain why *Dai*s' work has been 'packaged' by the GOG and WHO as community participation instead of paid health service. On the one hand, it relates to the origin of their work (women's work) and to *Dai*s' relationship to community members. On the other hand, it was to meet the needs of a health system without incurring extra expenditure by presenting work as a volunteer service.

Community participation as defined by WHO's HFA is based on a number of assumptions that imply equity, unfettered participation, access to resources, and the ability to make informed decisions. It also assumes that people from disparate background would be able to identify common needs and co-operate to fulfil them, which in this case is to achieve good health for all. Proponents of community participation further assume that individuals would be willing to work for the common good without any expectation of payment. The concept of community participation implies that poverty is the root cause of the lack of basic health care; however, it did not address how poverty could be tackled, nor did it address issues of gender discrimination or unequal distribution of power. For example, in Latin America, Ugalde (1985) noted that community participation is based on two false assumptions that allow international agencies and government officials to intervene in the community. These include the belief that the traditional values of the poor are the main obstacle to development and health improvement and that the poor are incapable of organising themselves. Cooke and Kothari (2001) identified participation as new tyranny. They noted that labels such as 'community,' 'local knowledge,' and 'empowerment' that form part of the development and participation discourse hide the latter's exploitative nature. Indeed, what constitutes community participation is dependent on how participation is perceived, who defines participation, and whose perception(s) is used to evaluate whether participation is implemented as intended to achieve the objectives. Answering these questions means understanding the power of authoritative perception in influencing policies. For *Dais*, the community participation is determined by the authoritative perception of the Gujarat government.

Community participation has been identified as part of a multisectoral effort to ensure that individuals have access to basic health care, to develop human resources, and to empower individuals. The concept of community participation has put development squarely on the shoulders of individuals to carry out paid and unpaid work. Supporters of community participation have not examined the potential long-term impact on individuals carrying out unpaid work. Issues of under- or unemployment and its effect on income and work security have not been considered in community participation. Thus, understanding the assumptions on which community participation rests helps to provide some tentative explanations about *Dai*s' current socioeconomic position.

India's adoption of HFA as its working model means that it also embraces community participation, to which *Dai*s have become one of the many contributors. Community participation became the entry point for *Dai*s' into the mainstream health care system. But unlike with physicians, there was no formal contract put into place to guide *Dai*s' work in the health care system. The lack of a defined formal contract between the *Dai*s and the government has meant that *Dai*s have been situated in an in-between position—informal health workers within a formal health structure, but not part of the health personnel. Although their in-between position has given *Dai*s certain advantages, such as being able to move in and out of the system and having their contributions recognised, it has not served them well. RSHO's observations that *Dai*s are perceived as "*spare parts, excess, spare*" illustrate their disadvantaged position within the health structure of Gujarat.

At the outset, *Dai*s' entry as community participants can be perceived as a move to empower them. Having some input into the decision-making process would ensure that they do not remain marginalised. In reality, *Dai*s have not experienced empowerment; nor has their position changed. This is reflected in the valuation of their work. Although the Rs. 20 fee is recognition for their role in health, the amount does not depict the true value of their work. *Dai*s compare the fee with their daily earnings as agricultural workers and note that they earn twice as much for a day's work as they do in delivery work, which can take even longer. They also compare the amount that families pay to physicians or the cost incurred if the delivery is conducted in hospitals or clinics. Contrary to the common refrain by clients that *Dai*s receive a salary from the government, it appears that the Rs. 20 is a token payment in recognition that *Dai*s have followed the biomedical protocol of managing pregnancy and delivery. The Rs. 20 fee is not based on any mathematical formula that matches work output with monetary value. For example, the fee does not reflect whether the *Dai* stays with the client for a day or a few hours; the fee remains the same whatever the length of the labour. Furthermore, *Dai*s were not consulted when the Rs. 20 and Rs. 50 fees were set.

From my findings, one potential explanation for the mismatch of fees and work output is that *Dai*s' unpaid housework extended into the public arena. Because their work is unpaid, the logical assumption that would have been made is that it is difficult to predict its worth because it has none. If this was the assumption made by the Gujarat government, it would be correct to assume that it provided the government with a legitimate reason to name *Dais*' work as community participation rather than developing an economic framework. Another plausible reason to identify *Dais*' work with community participation is related to the common image of their work. Because their work is generally perceived and often portrayed as an altruistic service, the unpaid nature of community participation fits well with the overall sociocultural structure. Together, they legitimised the Gujarat government's move to ensure that basic health is accessible to people cheaply. Thus MOa's observation that "*Dais are helpful. They assist us without any remuneration. No one will provide so much service without any payment*" shows the extent to which unpaid work has become part of community participation. Instead of genuine participation, *Dais*' community involvement has become a way to provide health care informally through unpaid labour. According to Ugalde (1985):

> Community participation is also used for the promotion of self-help programmes. Construction through self-help (an euphemism for free labor) of feed roads, making lands adequate for agriculture, the building of irrigation, flood control and drainage systems, school buildings and health centres and in the shanty towns the development of the urban infrastructure, can free some scarce capital. . . . On the contrary, the evidence suggests that community participation has produced additional exploitation of the poor by extracting free labor; . . . [it] was a clever way to circumvent labor law and avoid labor conflicts. (pp. 43-46)

The historical underpinning of community participation and *Dais*' work has made it difficult for these birth attendants to change the mindset of the public and the government officials. It is unclear to what extent their suggestions, if solicited, would bring about changes in their payment or to their position as workers. As informal workers, *Dais* have no safety nets such as health insurance, pension plan, or provident fund to assist them when they are unable to work. My findings indicate that the current stance of the Gujarat government towards *Dais* does not align with the RCH framework. The CNA framework seems to focus on clients instead of *Dais* as women, as workers, or as health care consumers. For now, it appears that both the Indian and Gujarat governments have adopted segments of RCH for the CNA framework. Elson (1999) contended that

> there is a clear need for a transformatory employment policy; that is, a policy which helps to change peoples' perceptions of what is possible, beneficial and fair; fosters cooperative action; and strengthens women's bargaining power in the workplace, the home and the market place. (p. 622)

Community participation continues to subordinate *Dai*s to biomedicine instead of recognizing them as independent health workers. Because the development of human resources is recognised as key to good health, *Dai*s' subordinate position means that their access to knowledge is controlled through mass training, refreshers, and the type of information available to them. HKGujAdd2's reluctance for *Dai*s to learn about HIV/AIDS is based on a number of stereotyped images about *Dai*s that are linked to gender, women's work, social class, and patriarchy. *Dai*s' illiteracy is used merely as an excuse to limit their participation and access to knowledge in order to safeguard the medical establishment's monopoly on health care and information. Indeed, if illiteracy posed a barrier to learning, *Dai*s would not have been able to understand and disseminate information on family planning and maternal and child health. The discrepancy in perception of what the *Dai*s are capable or incapable of appears to be imposed rather than describing accurately *Dai*s' level of expertise. Thus Banerjee and Mitter (1998) observed that

> women like them [self-employed] are deprived of these rightful claims because they neither have the social contacts nor the political clout that are needed to get a hearing from the decision makers in these matters. The latter do not think that women, especially illiterate rural women, can be trusted with modern tools, money, or the power to make the right production decisions. (p. 3252)

Furthermore, *Dai*s' lack of accurate statistics on their work may be connected to their status as community participants/informal workers/unpaid workers. The lack of statistics has worked against them because they are unable to provide accurate documentation of their work, only estimations. *Dai*s' helping role further contributes to this statistical dearth. The absence of data on participation rate and work output has led health officials to identify *Dai*s' position as peripheral and as a "*weak link*" (HIASCGuj1) and to neglect their welfare as health workers, as observed by RSHO: "*In the department of health, though she is the most important person, she is also the most neglected individual.*"

Another reason for the lack of data could be that the multiple indigenous descriptions do not provide the strict categories needed for keeping statistics. One example is *Dai*s' description of birth defects. Unlike biomedicine, each *Dai* gave a unique rich description. It is important to understand that linking statistical evidence to value of work is based on biomedical standards that may not be useful in the indigenous context. However, it is critical for *Dai*s to develop some form of accounting framework to ensure that their work becomes more visible despite its being perceived as community participation.

Capacity Building and Work: Lessons From SEWA

The discussion so far shows biomedicine's authoritative views play a prominent role in defining *Dai*s' work. Because of its authority, its evaluation framework is presented as correct. Knowledge that does not fit into this framework is either ignored or considered incorrect. *Dai*s' knowledge and skills are invisible because they are not accounted for within the dominant system. Capacity building is the first among many steps to increase the profile of *Dai*s' work. As noted previously, those who have a poor perception of their work suffer from low self-esteem and vice versa. However, capacity building will be effective only if *Dai*s are aware of the above and are willing to address their invisibility. Building their capacity could enable *Dai*s to question the communities' and biomedicine's authoritative perceptions about their work and about them as health workers. It could also lead to another important step, and that is to present their work as distinct and yet complementary to biomedicine. Once this is achieved, *Dai*s could develop a frame of reference that would reflect their work accurately. But the crucial first step would be to instil in *Dai*s that they have the right to challenge the authoritative perceptions of biomedicine.

SEWA's authority lies in its 30-year experience of being involved in union work to better the economic and social conditions of self-employed women and to advocate for their increased participation in society. SEWA's development work shows that alternative economic strategies such as workers' co-operatives could assist women to gain steady income and work security. Its success stories of capacity building, co-operatives, social security initiatives, and mobilising women have enabled the organisation to position itself as an authoritative voice to speak on behalf of women, especially the poor. In all of its initiatives SEWA has shown conclusively the link between health and income and work. Through its work SEWA has illustrated that the fundamentals of *Health for All* and *Reproductive and Child Health* can be implemented at the ground level.

SEWA's critique of the Gujarat government's vision of RCH is precisely that *Dai*s are excluded from it. *Dai*s do not seem to have a role in the transition from primary health care to RCH even though the participants at the ICPD conference had alluded to the fact that women lack the opportunities to be involved at the policy level and in the decision-making process. SEWA perceives that the current approach of RCH in Gujarat further marginalises *Dai*s despite their being integral members of the health team. This is because SEWA's initiatives stand in direct contrast to the Gujarat government's approach of working with *Dai*s. SEWA contends that RCH is not equitable if *Dai*s, who are some of the poorest of the poor and who provide accessible delivery care, are excluded in the process of RCH. Thus SEWA's critique carries weight because of its grassroots work and proven track record of effective mobilisation of *Dai*s and other women.

Two authoritative perceptions with different philosophical base are competing to convince *Dai*s that their particular version is correct because it has *Dai*s' welfare in mind. The Gujarat government has presented its version that its goal is to ensure that women have good and safe delivery services; SEWA presents its case by showing that its initiatives for *Dai*s are inclusive and innovative because it wants to address the status quo and build *Dai*s' capacity.

*The SEWA Dai Co-operatives: Building Dai*s*' Capacity Through an Alternative Economic Strategy*

It is difficult to state with certainty whether capacity building or work comes first in order for women to have good health. Leaders of SEWA have stated that income security and work are crucial for women before they are ready to address other issues including their own health. At the same time, if women do not have a sense of self-worth to challenge gender bias, the cycle of low self-esteem and poor physical health will be perpetuated. What is clear from my findings is that for poor women economic empowerment and capacity building need to be promoted concurrently because they are critical to women's well-being.

SEWA found that women in the informal sector are trapped in the vicious cycle of poverty and debt because they lack access to direct credit. The literature indicated—and SEWA membership reflects this—that women in the informal sector often work long hours and are engaged in low-skilled, low-paid, repetitive work. Their income barely meets their daily basic needs. Together, these exact a heavy toll on their physical and mental health.

SEWA's answer to *Dais*' need for income and work security was to establish co-operatives. Like other SEWA trade and service co-operatives, the goal was to address *Dais*' invisibility as informal workers, to empower them (economically and socially), and to provide them with opportunities to access new information and technology. SEWA's initiative provides a reference point to compare with the government's efforts to improve the *Dais*' socioeconomic situation. Unlike the government's stance that *Dais* are to be phased out because they are a weak link, SEWA is moving towards integrating them and providing them with the means to become economically independent. The organisation sees co-operatives as an alternative strategy to address poverty and reduce the burden of debt of poor women such as *Dais*. The establishment of *Dai* co-operatives shows there is a need for alternative approaches to explore what lies behind the monolithic terms of *women's work* and *housework.*

When women's unpaid housework becomes paid work for an employer, as marketed by SEWA *Dai* co-operatives, it appears that the binary paid/unpaid and informal/formal work is the result of social conventions. These demarcations allow for control by those in power to determine the type of work, the qualifications needed, and the rate of remuneration. *Dais*' membership in co-operatives and their ability to earn an income indicates that the simple label of *women's work* hides a complex relationship of gender, skill, and economy. Questions such as what a skill is, how it is defined, how its value is determined, and who determines the value of the skill influence the gendered meaning of *Dais*' work. These questions support the view that work is a social construct subject to multiple interpretations.

The range of co-operatives under SEWA shows the diverse nature of "women's work." It appears that SEWA's function is to encourage women to break away from the traditional mould of paid and unpaid work. The implication is that unless women learn to seek alternative strategies to value and present their work, the continued reliance on mainstream economic structures will hamper their ability to move forward and impede their effort to break the cycle of exploitation, poverty, and ill health. *Dais* face multiple hurdles to achieve this. The biological nature of birth (women's work), the social identification of management of childbirth as women's work, and the cultural nuances of birth (polluting and untouchability) means that they face a triple burden of changing the mindset of society and even of *Dai*s themselves. However, SEWA *Dai* co-operatives show that negative cultural connotations of work can be overcome if *Dai*s learn to value their work using a framework that builds their capacity. The *Dai* co-operatives therefore question the standard definition of work/nonwork and skilled/unskilled. This shows that indigenous midwifery could be a form of self-employment and that women could command a price for their service.

Furthermore, SEWA *Dai* co-operatives present another strategy to mainstream gender in the economic structure. Gender mainstreaming allows policy makers to be aware of the unique situation of women workers and the barriers that they encounter. For SEWA, gender mainstreaming includes having all-women co-operatives so that women's voices are not silenced and lobbying with the government for increased participation of women. SEWA's initiatives for *Dai*s take into account the central role of gender and the gender bias that women experience in South Asia. SEWA's critique of the government's RCH framework is rooted in what it sees as the lack of gender mainstreaming in its health policies, whereby few or no opportunities are found for *Dai*s. By integrating gender in all its work, the organisation shows that policies sensitive to women's needs are a step forward in addressing structures that discriminate against them, contributing to their well-being. The increased self-esteem of SEWA *Dai*s attests to this. Some break the societal constraints imposed on them, others challenge the stereotyped images of their work, and still others have found the courage to speak in public. In whatever roles they find themselves, the fact that they are able to do what was once impossible gives them a sense of freedom and a feeling of self-worth.

SEWA's success in mobilising *Dai*s provides valuable insights for those who are working with marginal populations. Parameters used to assess productive work in the mainstream economic framework should not be used to assess the work of those whose contributions do not fit into that framework. Traditional methods of defining productive work will continue to exclude and disempower informal workers. Although *Dai*s want to be included in the mainstream, their exclusion from the formal health sector is because their work and knowledge are evaluated based on a biomedical body of knowledge. The mismatch of two systems of knowledge does not provide useful data on *Dai*s' work and skills. Alternative strategies must be used to understand the real value of their contributions. In addition, *Dai* co-operatives provide a model for economic self-reliance within the local and global contexts. *Dai*s are learning to develop multiple skills (through their school) to provide accessible and affordable basic health care. By creating a local niche for themselves such as above, it appears that SEWA *Dai*s are preparing for the fluctuations in the global market such as the disbursement of international funding for health initiatives.

SEWA co-operatives show that alternative economic strategies can succeed in a mainstream financial structure when efforts are made to accommodate them. Taken together, SEWA *Dai*s are empowered to determine the direction of their learning and control the types of services they want to offer. In addition, the co-operatives provide a safe environment to establish social support and network and exchange ideas. It is a social and economic framework that has dual functions: to empower *Dai*s and to build their work and income capacity. *Dai*s' ability to act as a collective and mobilise through economic venture contrasts to the findings in the literature that portray *Dai*s as powerless.

The SEWA Dai School: Capacity Building Through Access to Knowledge

Another strategy that SEWA has used to build women's capacity is to provide them with avenues to enhance and expand their knowledge base. Women suffer the effects of gender bias, which restricts their access to information and technology. The literature showed that the impact of the gap is more acute for women in the informal sector. Many are either displaced formal workers or products of under-/unemployment and do not have access to information to assist them to take advantage of emerging market trends. As a women's organisation, SEWA recognises this gap. That is why SEWA's emphasis on knowledge acquisition appears to be critical to address the vulnerability of poor self-employed women.

The *Dai* School appears to be both a tool and a product of capacity building. As a tool it would enable *Dai*s to create a body of knowledge that would determine the scope of practice. The school would provide *Dai*s with an important platform to develop an authoritative voice to support their work and contributions. More important, the school is a step toward meeting the aspirations of SEWA *Dai*s who wish to access new information as they become aware that their previous way of doing may not be viable in the changing health structure. Like other paramedical and medical workers who have gained professional status through their respective institutions, the SEWA *Dai* School follows a similar step to establish professional standing for *Dai*s to give them the political clout that otherwise is not available. Professionalisation has the potential to change the perceptions of outsiders about *Dai*s and thus affect *Dais*' self-esteem and prestige. Indeed, the move to integrate certain biomedical practices with their indigenous knowledge challenges the assumption that *Dai*s are unable to change or adapt to new knowledge. The logical conclusion about this dissonance is that it serves the interests of outsiders to legitimise their interventions and implement their own version of change. Paolo Freire (1970) called this type of education the *banking* style, in which learning does not liberate but further oppresses. According to Freire, a humanist education is one that is developed with the consultation of the people in order to free them. The setting up of the SEWA *Dai* School appears to be based on the latter model, which allows for dialogue between *Dai*s and SEWA. The school therefore becomes a tool for critical thinking for *Dai*s to articulate how they see their world instead of imbibing how others see their world. The ability to speak without fear is itself a step towards capacity building. Freire noted that the displaced fear speaking and remain silenced because they ask, "How can I dialogue if I am afraid of being displaced, the mere possibility causing me torment and weakness?" (p. 79). Thus the SEWA *Dai* School begins with the premise that *Dai*s' indigenous skill and knowledge are relevant and that, as women workers, they are in a better position to articulate their learning needs. The school therefore becomes the medium for initiating changes in a safe environment where they know that they will not be silenced.

The SEWA *Dai* School represents a significant step for these birth attendants. Establishing a formal school of their own could be a sign that *Dai*s are learning the importance of an alternative framework to legitimise their work and to increase their visibility. The *Dai* School points towards a fundamental change of how birth attendants perceive their knowledge and contextualise their contributions in the overall health structure. It could be an indication of *Dai*s' awareness that a shift is required in the way that they relate their work to the world. Freire (1970) named this awakening to one's political, economic, and social situation *conscientisation*. Freedom from oppression occurs when conscientisation takes place and individuals are able to decide the course of action (Freire, 1970). SEWA appears to play a prominent role in *Dai*s' conscientisation because they trust SEWA. *Dai*s know that the organisation understands their economic concerns and that, unless women have secure income and work, all other initiatives will fall by the wayside. *Dai*s' confidence in the organisation is based on the fact that it is poor women like themselves who are both members and decision makers of SEWA. Over the years *Dais*' capacity has increased because SEWA has implemented innovative schemes (co-operatives and identity cards) once thought impossible for poor women. It appears that SEWA's approach to conscientise *Dais* is two pronged. The organisation is attempting to teach *Dais* that their economic well-being is closely linked to their level and type of knowledge. But, more important, SEWA's message is that *Dais* have the right to access and enjoy the benefits of new knowledge and technology in health care. *Dais*' inability to read or write need not be a barrier to develop their capacity, but rather education could become a social and economic leveller. In that way *Dais* would not be ignored but considered to be among the ranks of legitimate health care workers.

It is difficult not to emphasise throughout that SEWA's approach to human resource development differs from that of the Gujarat government. Whereas the Gujarat government perceives *Dais* as a weak link who will likely have no place in a 'well-equipped' health care structure, SEWA considers them as an asset that needs to be developed in the evolving health system. It appears that SEWA's vision of human resource development coincides with the recent findings of various authors at an HFA meeting in Halifax, Canada. The authors found that in many countries a chasm exists between human resource development and health needs because governments have pursued policies that are intended to correct the gaps in human resources instead of comprehensive approaches to develop human resource to meet the health needs of the population. In this context it appears that the SEWA *Dai* School is a step not only to meet the shortage of health care workers, but also to develop the skills of indigenous midwives. With the SEWA *Dai* co-operatives, *Dais* equipped with multiple skills would have other avenues of earning income. The Gujarat government, on the other hand, has not addressed the critical issue of what measures it has put into place to ensure that *Dais* have alternative work and a source of income when they are phased out. This has serious implications for *Dais*' physical and mental health. Because poverty is a cause and a consequence of ill health, the lack of choices for *Dais* will worsen their already precarious economic status and further push them into the margins. Thus it may be prudent for the Gujarat government to address the consequences of *Dais*' displacement before phasing them out. Otherwise it will create another health problem for both *Dais* and their clients while attempting to correct the existing shortage of staff for delivery care and maternal health services. According to Banerjee and Mitter (1998):

> Rather than treating science itself as the enemy of the people, it is necessary to recognise the class- and gender-based power play that is involved in the process of scientific development. In making decisions in this matter, those in authority often make a disproportionately large allocation of the available scarce resources for the exclusive benefit of their own peers. . . . Unless these underlying power relations are changed drastically, the potential of science and technology will continue to be used only to the disadvantage of poor women. . . . In short, the gendered construction of women workers had made them especially vulnerable to technological redundancy. (pp. 3253-3255)

The development of human resources is critical for women because it has ramifications beyond their work. SMeh7 pointed out that training has the potential to impact future generations who could bring about changes in the community. It is well known that girls benefit when their mothers are educated and employed. Furthermore, SEWA's decision to use their own members as trainers provides these women with opportunities to develop their skills and build their capacity. This indicates that SEWA is aware that its *Dai* School is in a strategic position to develop its human resource at multiple levels.

Despite the advantages of a formal school for *Dai*s, there are certain disadvantages that SEWA has not directly addressed. For example, there is a potential that the school could give rise to social and economic stratification among *Dai*s similar to that found among biomedical health caregivers. Just as physicians, *Dai*s may compete (between SEWA and non-SEWA, and among SEWA) with one another instead of working together to correct the structural inequities. There is a potential for the training to lead to two cadres of *Dai*s, which could give the impression that one group is better trained, equipped, and skilled than the other (untrained). *Dai*s' internalisation of the binary trained/untrained reinforces the values of the dominant group. Instead of education as liberation envisioned by Freire (1970), education becomes a tool for oppression. Although certification gives legitimacy to training, skills, and work, it excludes those who are unable to learn the didactic way. Certification excludes those who do not fall into the accepted norms and does not accommodate a different way of transmitting and learning knowledge. It is understandable that SEWA seeks certification from the Gujarat government, but there is a potential that in the long run it could curtail *Dai*s' economic independence. Other criteria such as age, educational status, and cost of training could be used to exclude them from training or practice.

The government could also create artificial supply and demand to restrict the number of *Dai*s trained per year to control the health care costs. This could lead to many *Dai*s losing their source of livelihood. Instead of *Dai*s being the decision makers, their curriculum and work become pegged to the government's and other stakeholders' needs. It could lead to *Dai*s' interests being subsumed by the overall heath structure and marginalising them. The certification of skills based on changing criteria and the shifting boundary between *Dai*s and stakeholders derives from the understanding that supports the contention that work is a social construct.

The advantage of uniform curriculum is that it standardises disparate practices and knowledge. However, it could lead to deskilling of *Dai*s, which could have a profound impact on their confidence when they learn to rely on set procedures and work becomes routinised, repetitive, and uniform.[187] There is a possibility that *Dai*s' previous experiences and judgement could become subsumed to the algorithm that specifies steps for safe births. What may happen is that anything that deviates from the algorithmic steps calls into question the validity of their judgement and experience. Instead of building their capacity, a uniform curriculum could potentially erode *Dai*s' confidence and indigenous knowledge. Although Banerjee and Mitter (1998) argued that the glorification of indigenous practices has been detrimental to women's attempts to move forward, the authors did not address the issue of deskilling that Sandall (1996) found in her study of British midwives. On the other hand, Elson (1999) contended that equitable public policies are key to ensure workers' well-being:

> The role that can be played by public policy in setting standards for wages and working conditions is thus two-fold: to shape perceptions and set norms about what is ethical and unethical, and to create an environment in which all enterprises face similar standards and thus cannot obtain competitive advantage by paying wages that are below subsistence level and enforcing working conditions that endanger the well-being of the workforce (Elson, 1999, p. 623).

In summary, the SEWA *Dai* School provides various avenues to address *Dai*s' capacity. It focusses on their skills, their contributions as women workers, and the role of gender in Gujarat. The school is proof that women who are in the margins are capable of articulating their learning needs. SEWA is aware that *Dai*s' financial well-being is linked to their knowledge and to how it is perceived by the government, clients, and other stakeholders. Although the RCH and HFA frameworks recognise informal learning and indigenous knowledge, SEWA's decision to avoid the possibility of its school being seen as "*too alternative*" appears to be valid. This is because it does not want to isolate *Dai*s. The organisation's ultimate aim is to mainstream *Dai*s' work so that they become formal workers and receive financial and social benefits, and to ensure that their work is accounted for in the economic system. As a women's organisation, it is aware of the gendered nature of *Dai*s' work and thus its low value. Through education, SEWA's goal is to teach *Dai*s that their work is valuable and to promote the message amongst its members that, as valuable workers, maintaining good health is critical. Only then will they be able to address issues related to gender bias.

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[187] Similar observations have been made in other groups by Kishwar (1997), Mojab (1999), and Rinard (1996).

Conclusion

Power is at the root of authoritative perception. Authoritative perception is accepted because it is presented as correct, convincing everyone that it reflects the actual reality of the situation. Alternative views become absorbed into the authoritative perception, thus ensuring the latter's implementation and acceptability. More important, authoritative perception silences the voices of individuals who may challenge its authority. The silence of competing views reinforces the power of authoritative perception and its proponents. The groundwork established through authoritative perception becomes the starting point to influence issues at hand. This is the central theme of this current study.

Authoritative perception remains central no matter how varied the issues are that affect *Dai*s and their work. Organisations use their authority to create certain realities, which provides them with the opportunities to formulate solutions to these realities. The GOI, GOG, WHO, and SEWA have in their own respective ways created certain images about *Dai*s and their work. In doing so, each claims that it has identified *Dai*s' real needs and has formulated solutions to meet those needs. Although it may appear that *Dai*s lack power to resist these interventions, this perception is misleading. *Dai*s' power is displayed in a number of ways that have allowed them to be agents either to accept interventions made on their behalf or to reinforce the sociocultural views because *Dai*s perceive them to be advantageous.

To this end, the current study using multiple perceptions of *Dais*' work has filled the gap. It shows how one group of women health workers conceptualise their work at both the personal and community levels and the effect on their health. *Dais*' work provides a unique case because it is feminised work, performed by women who are marginal, at the grassroots level. My evaluation of the three frameworks shows that even when terms, programmes, and policies appear equitable, they may adversely affect individuals once they are implemented. Certainly the frameworks encourage health to be viewed holistically, moving away from the narrow interpretation of absence of disease. This move fits well because there is an increasing awareness that women's health and the burden of disease differ from those of men. Health initiatives that address women's well-being must take into account their social, economic, and political status, especially in a stratified society. In most societies women assume the triple burden of caring for their families, performing household duties, and earning income. *Dais*' work indicates that employment presents opportunities to women, but it is dependent on the type of work performed.

International perspectives play a prominent role in influencing the direction of health policies. The UN presents the HFA and the RCH as equitable and inclusive frameworks that encourage multiple participation at the grassroots level. When examined closely, each framework shows that grassroots participation is initiated from the top down, even though community consultation and a needs-based approach is promoted. What has been found is that apriori decisions by policymakers continue to influence the direction of health care, a point that both Foster (1987) and Stone (1986, 1992) noted.

Formulators of HFA assumed that the involvement of indigenous healers would be advantageous for them, but the HFA participants did not anticipate or consider the negative ramifications to the indigenous healers from this informal relationship. *Dais* experience ambivalence because their involvement has not brought about any significant, tangible benefits either in the level of remuneration or involvement in the decision-making process. There is a dissonance between the goals and expectations of the HFA and its implementation in India with *Dais*' realities. The WHO and the GOI have approached the provision of delivery care based on their respective authoritative perceptions about the extent of indigenous midwives' involvement. Last but not least, the joint statement of WHO/UNFPA/UNICEF (WHO, 1992) convinced member countries that delivery care would be accessible once the indigenous midwives were involved, but it did not add that equitable policies must be implemented concurrently to address the inequities in the social, political, and economic realms that impede women's development and affect their health and work.

An interesting point to note here is the skill with which both the WHO and the UNFPA have gone about creating a credible image as upholders of social justice, promoters of sustainable development, and champions of marginalised segments of the population. They have done this through the language of the frameworks and their co-operation with governments and NGOs. When the WHO (1978, 1992) suggested that indigenous midwives be included under community participation, it was considered to be a correct move by health policymakers. By encouraging integration of the midwives, the WHO focussed on the needs of the health care system and overlooked the socioeconomic needs of these midwives. This inequity in the HFA is projected as just and fair. Questions regarding payment, such as what is an acceptable level and what formula should be used to determine equitable remuneration, were omitted. By not addressing the issue of remuneration and not suggesting the possible benchmark to calculate fair wages, the stage was set for indigenous midwives such as *Dai*s to provide cheap labour and assume the burden of health care without being adequately compensated. This is possible because of WHO's authoritative HFA framework through which it has skilfully established images of ideal indigenous midwives and implied that their contributions are crucial to ensure the well-being of women.

Freedom to interpret HFA and RCH has further enabled the GOI to institute policies without actually changing its previous position. This is clearly seen in the GOI's CNA documents. Population control continues to be the mainstay of Gujarat's and India's health initiatives despite attempts to portray otherwise. Therefore perspectives presented in an authoritative manner can camouflage the lack of changes. It appears that the *Dai*s' position may not undergo any change in the new RCH health structure. As women who are in the margins and who survive under precarious economic conditions, there seems to be no provision in the CNA to address their low socioeconomic status or to build their capacity. Clearly, an authoritative policy statement could continue to be unjust and still be considered as just and correct.

Despite the mismatch between the intended goals and policy, there is a general acceptance of the CNA. In fact, the mismatch is further accentuated in the way the government has gone about in engaging *Dai*s. *Dai*s are encouraged to upgrade, and they are told that they are important members of the health care system, and yet there is a tacit understanding among health officials that eventually *Dai*s will be phased out. The GOG has reconciled this contradiction by making the link between high IMR and MMR in the absence of biomedical care despite the fact there are other socioeconomic and cultural factors that contribute to high mortality ratios. In all these, the GOG has been successful in presenting a particular aspect of maternal health because it uses its authoritative perception to convince stakeholders that its version is the correct interpretation of Gujarat's health care system.

*Dai*s' work illustrates that work is a socially constructed phenomenon. Their work assumes multiple values depending on the perceptions of various stakeholders. Primary health workers appreciate *Dai*s' contributions, whereas health officials of Gujarat view *Dai*s' involvement as a sign that the health care system is inadequate. Clients, on the other hand, consider *Dai*s as a viable alternative to access delivery care. SEWA perceives *Dai*s as valuable members of Gujarat's health care team. Its goal is to ensure that these women have secure incomes and work and eventually become part of the mainstream. Each group has created its own authoritative perceptions to perpetuate its values and beliefs (even when these are contradictory) about *Dai*s and to engage *Dai*s to meet their needs.

Exploring work as a social construct reveals the contested nature of the monolithic term that describes women's work, thus allowing for better grasp of the meanings of paid/unpaid work and skilled/unskilled. In recent times *Dai*s' work has become an avenue to transmit new knowledge and beliefs from a different system, the biomedical system. In fact, *Dai*s are the link for international agencies and the Gujarat government to intervene and access community members. In all of the literature on *Dai*s' work, this strategic link has not been acknowledged. *Dai*s are often portrayed as powerless women who do not have the wherewithal to resist external manipulation. Although at some level this is true, it is a simplistic notion. Holding onto this notion has only served the agenda of those who need legitimate reasons to intervene without any resistance. The findings of the present study show that *Dai*s are astute women. They have formulated strategies to address these stereotypes. Their resistance is manifested in two ways. First, they have joined SEWA *Dai* co-operatives and the school, where they learn to articulate their needs and build a sustainable economic base. Second, they have used the cultural interpretation of good to create the perception that they are indispensable. *Dai*s have been able to do this because of their community support. *Dai*s are neither powerless nor incapable of establishing their authority. Although the strategies that *Dai*s use may differ, their underlying goal to create their own authoritative perceptions and to influence opinions does not.

SEWA's authority is based on its intimate knowledge of the needs of self-employed women. The important point to note is SEWA's advantageous position. Although one of its mobilisation activities (training) is similar to that of the Gujarat government, its work carries weight because *Dai*s perceive SEWA's interventions as for their benefit instead of the organisation's. SEWA has used its image as a champion of women's issues to encourage *Dai*s and formulate strategies to build their economic and social capacity. Hence, SEWA's intersection is critical for building the *Dai*s' capacity, and at the same time its involvement with *Dai*s and in other community development work enhances its standing among women and internationally.

Like all concepts, authoritative perception is a socially constructed phenomenon. Its conceptual framework has been useful in this current study because of its ability to provide a logical coherence to health policies and initiatives that appear contradictory. Understanding the emergence of authoritative perception from multiple perspectives is also crucial because it provides insights into the role of power—the various levels and degrees of power and how it is utilised. More important, the contextualisation of authoritative perception shows the need to question and to look at issues critically because a favourable policy may not have benign outcomes.

CHAPTER 9

CONCLUSION

Good health occurs when basic needs are met. Both the joint WHO/UNICEF (1978) *Health for All* and the UNFPA (1994) *Reproductive and Child Health* suggest a multisectoral framework to facilitate good health. The aim is to seek alternative ways of addressing health, one that goes beyond the biomedical approach. The goal is to have a better understanding of why basic health care continues to be out of reach despite efforts to address this gap. For example, the literature indicates many women in the South do not have access to basic or maternal health care, especially during maternal emergency (WHO, 1998c, 1998d, 2000a). Within this context, indigenous midwives in these countries appear to be in a strategic position to provide women with maternal health service despite their limited resources.

Lack of accessible basic and essential obstetric emergency care is one reason for the high maternal mortality and morbidity rates in the South. It is a well-known fact that poor maternal health results in social and economic losses at the personal and national levels. Women die during pregnancy and childbirth from either direct or indirect causes. It is within this context that *Dai*s' contributions are examined.

In Gujarat, *Dai*s provide valuable service but they remain in the margins in the overall health care system. *Dai*s conduct the majority of deliveries and in many instances, they may be the only source of health care assistance for women during their childbirth process. Their involvement highlights a central issue—because of *Dai*s, women in Gujarat have access to an affordable and accessible form of labour and delivery services and other primary health care. Although other factors such as poor nutrition, lack of basic education, poverty and social structure that favours males over females contribute to the high IMR and MMR, there is a widespread belief among biomedical establishment and health officials that *Dai*s contribute to Gujarat's high mortality statistics. Based on this belief, the goal of engaging *Dai*s since 1957 has been to change the way *Dai*s practice. This approach has not been advantageous for *Dai*s because it devalues their role as health care workers. The literature on *Dai*s recognise their contributions in relation to women's health and how they bridge the gap in the health care system. As a group, their socioeconomic needs and other health concerns have either not been discussed or mentioned briefly or superficially. Their precarious economic state and its effect on their well-being has not been addressed.

There is a general consensus in Gujarat that is further supported by the literature (Bajpai, 1996; CHETNA, 2000; Jeffery et al., 1989; SIHFW, 1999; Smith, 1998), that *Dai*s are important because they are accessible (culturally, geographically and financially) to women. Yet their socioeconomic position neither reflects their importance nor gives a true picture of the value of their contributions. The present study suggests that one reason for this contradiction is *Dai*s' ambiguous position in the health care system. They are part of the formal health care structure but at the same time, remain informal health workers. Unlike other biomedical health workers who have defined roles, *Dai*s do not occupy a definite place in the overall health care structure and find themselves occupying the in-between space. This is not surprising considering the nature and definition of informal work and those who fall in this category. As noted in Chapter 5, the various names by which the informal sector is known illustrates its marginality and exclusion from the formal economic framework, masks the extent to which the informal sector exists and obscures the support it provides to the formal economy. In addition, its low value is compounded by the fact that its members are predominantly women and the work performed is generally of low technological base. Thus not only the informal sector by its nature is perceived as temporary, but the predominance of women and the perception that their work is temporary and supplemental means that women who work in the sector experience the triple burden of exclusion/invisibility, work long hours and low pay. Contextualising *Dai*s' work within the informal work framework gives a better understanding as to why *Dai*s are marginalised. *Dai*s and their work fit the informal work definition and the overall definition of women workers. However, *Dai*s' in-between position in the formal health system compared to other informal workers could also be considered as advantageous. This is because unlike other informal women workers, *Dai*s maintain a foothold in the formal sector because the government continues to engage with them.

The present study uses the conceptual framework of authoritative perception to explore the work of *Dai*s (see Chapters 6, 7 and 8 above). This has led to a better understanding of *Dai*s' current socioeconomic status in Gujarat and provides the basis for analysing previous initiatives. In addition, the concept of authoritative perception is useful in explaining the contradiction in the way *Dai*s are engaged by the biomedical establishment, health officials and community members and also highlights the complexity of *Dai*s' work. On the one hand, *Dai*s are provided with training and DDK to assist them with work and are told that they are needed and important. On the other hand, the Gujarat government's goal is to phase them and not to 'train' any new *Dai*s. Thus the contradiction is the acceptance and implementation of health policies that appear inconsistent with the intended goals but considered correct. As noted in Chapter 8, power is central to the success of authoritative perception. Those in authority use their power to convince others that the way the issues are interpreted and addressed is correct and therefore just. Although Bajpai (1996), Jeffery et al., (1989), Smith (1998) and Stephens (1992) have alluded to *Dai*s' social position, it has been in relation to the meaning of birth and delivery in the overall cultural framework. The role of power and perception, particularly authoritative perception, and its effect on *Dai*s' development and health, has not been fully explored. This study addresses this gap by demonstrating the central role of authoritative perception in influencing the direction of *Dai*s' work, access to resources (remuneration, clients and knowledge) and their future role within the health care system and social status.

Previous literature on *Dai*s (Raina & Kumar, 1989; Seymour, 1997; Sharma & Bali, 1989; Swaminathan et al., 1986; Wasan, 1982; Walia, 1986, 1994) that focussed on the *Dai*s' inability to adhere to biomedical standards and procedures, however, did not mention the less than optimal environment that many *Dai*s find themselves in when conducting deliveries. While there are *Dai*s who resort to harmful practices, this omission on the role of the environmental context meant that the picture that emerged about *Dai*s and their work was inaccurate. It also devalues their contributions, minimises their role as health workers and reinforces the old stereotypes. The findings in this study show that *Dai*s work in places where access to medical care or availability to care is not possible or in situation where immediate intervention is critical. By not considering the environment, the critique that *Dai*s are resistant to biomedical techniques appears to be simplistic. However, it is also important to ask why previous stereotypes continue to persist. One logical explanation, according to this study, suggests the role of authoritative perception and the ability of individuals to convince others that their perspectives represent the correct views about *Dai*s' work. The influential role of authoritative perception further explains the inconsistencies in the way *Dai*s are engaged and provides the basis for understanding the contradiction between the belief that good health is the result of a multisectoral effort (HFA and RCH) and the one-sided approach of contextualising *Dai*s' work.

Indeed, the continued focus on *Dai*s' practice reinforces the previous observation made in Chapter 8 that integrating authoritative perception promotes status quo and prevents change. Instead of addressing the difficult environment in which *Dai*s work, the status quo linked to authoritative perception provides the Gujarat government with the means to shift its focus away from removing the difficulties that affect *Dai*s' work negatively. As noted in Chapter 2, the broad interpretations of the HFA and RCH frameworks allows for status quo. The generalisability of health frameworks has enabled the GOI and GOG to continue with previous health strategies such as population control and yet project it as a new paradigm as in its formulation of CNA. The CNA does not seem to address the health of marginal women such as *Dai*s or to enhance their socioeconomic position. Indeed, India's focus on population control is linked to its national development goals. There appears to be an official perception that unless the rapid population growth is controlled, economic gains will continually lag. It is only through integrating the conceptual framework of authoritative perception into the discussion of health framework that this becomes clear.

My findings show that authoritative perception is central in achieving multisectoral cooperation. Authoritative perception(s) influence the distribution of resources and interactions among stakeholders. This knowledge is critical for the future formulation of health policies at international, national, and local levels. SEWA has shown that health policies (or any policies) attuned to the needs of the target population have a greater chance for success. Its own success with women of other trades and services and its work with *Dai*s demonstrates this fact. There is a greater cooperation between SEWA leaders and poor self-employed women because the latter perceive that their leaders understand their economic anxieties and are working towards addressing their concerns. Two key findings emerged when multiple perceptions were collated to explore *Dai*s' work. First, the social and monetary values of *Dai*s' work are dependent on their ability to meet the needs of individuals and the health care system. Second, the relationship between *Dai*s and stakeholders is based on how these individuals perceive *Dai*s meet their needs.

However, it is also important to note that it is not just outsiders' authoritative perceptions about *Dai*s that influence the value of their work. *Dai*s are agents of change. *Dai*s (SEWA and non-SEWA) play a role in either creating new, or perpetuating old, images. The various images become the platform for interaction that not only determines the outcome, but also shapes future expectations. For example, authoritative images created through *poonya ka kaam* and *dharm* provide a desirable cultural framework for *Dai*s' work. These social markers give *Dai*s a certain level of control and social prestige and, for a while, remove the unfavourable cultural connotations of childbirth and delivery work. Identifying their work with these cultural labels indicate that *Dai*s and those around them do value *Dai*s' work. At the same time, clients perpetuate these images because they provide them with accessible delivery services and at times, remove the onus to pay *Dai*s. *Dai*s themselves reinforce the cultural authoritative perception that their work is to render help to women. *Dai*s do this despite the negative effects on their income because it is a way for them to deal with their powerlessness and reconcile their marginal position. On the other hand, the possibility that *Dai*s want to maintain a status quo cannot be ruled out. The cultural connotations of doing good work and the authority it commands in the South Asian culture means that the *Dai*s understand that any move to bring about changes could lead to negative repercussions. Generally maintaining status quo is not considered beneficial, however, in this instance, it is to the *Dai*s' advantage to promote this authoritative perception because it enhances their reputation and portrays them indispensable.

Thus any discussion whether *Dai*s control or value their work must be done within the existing sociocultural and economic contexts. Although *Dai*s do value their work (culturally), their valuation is also dependent on how society affirms *Dai*s' perceptions, and this in turn influences the extent of control *Dai*s may exercise. It is a cyclical process. But external pressure to conform to the dominant system (biomedical) and the inability to influence either their remuneration or professional status creates a sense of ambivalence among *Dai*s. They continue to exist in the margins politically and economically. Therefore control and valuation are not clear cut but are complex, fluid, and contextual, and the framework of authoritative perception shows this clearly.

Understanding the role of authoritative perception has helped to provide insights into why *Dai*s' work continues to be identified with housework and considered to informal. The image of women helping women, coupled with the fact that it is predominantly performed by women in the home, is one reason. Comparisons between the biomedical way of conducting deliveries and the indigenous methods do not take into account that two diverse systems are at work with different philosophical stances. Continued focus on the lack of clear division between personal and professional roles of *Dai*s compared to those of biomedical workers also does not take into account the subtle ways that *Dai*s and clients negotiate with one another using various cultural symbols. Qualitative research methods described in Chapter 6, however, correct the misconception, and the multiple perceptions presented in Chapter 7 reveal clearly that *Dai*s follow certain professional protocol to manage their relationship with other *Dai*s, clients, and biomedical health workers. The seemingly informal nature of *Dai*s' work conceals the intricate network that ensures that reciprocal ties are maintained and called upon when needed. Referrals by word of mouth and being perceived as a good person and as a skilled *Dai* all influence a *Dai*'s earning capacity. These factors also play a role in the biomedical system; however, they are not emphasised because the image of professionalism and authoritative knowledge presented as objective and scientific override them. This could explain why the same work performed in the home by female biomedical personnel is not perceived to be housework. The continued promotion of indigenous midwives' work as part of housework justifies their low pay and reinforces their marginal status. Waring (1988, 1997) and others (Ghorayshi & Lebanger, 1996; Greve, 1997; Martens, 1994) question the mainstream economic framework that compartmentalise work according whether it is paid or unpaid and instead challenge that the definition of work be widened to include home-based and housework as part of the economic valuations of work.[188]

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[188] Recently in a newspaper article titled, *What's the Worth of a Housewife's Labour?* the Minister for Department of Women and Family Department, Shahrizat Abdul Jalil announced that a nationwide study is being planned to put a dollar value to the work done by housewives in Malaysia. The study, which begins tomorrow (April 21, 2003), will quantify the contribution of unpaid workers, especially housewives, to the economy in dollar terms. The goal of the nationwide survey is to provide the missing statistics on the contributions of those outside the labour market. According to the Minister, the housewives would be asked how they apportioned their time between household chores, sending their children to school, doing voluntary work and spending time on themselves. The time devoted to their daily routine would be recorded for two days and from the feedback received, the Ministry wll be able to enact a policy that is suitable to the needs of housewives. Furthermore, the Minister indicated that the study would help recognise the contribution of housewives to the country's economic output. She noted that "When talking about women's contributions, we usually focus on professional women in the labour market like doctors and accountants. Rarely do we look at housewives' contributions. With this study, we hope to see objectively contributions of this group." Malaysia has 3.84 million women aged between 15 and 64 who fall outside the labour market and of these, about 3 million are housewives. The Minister observed that "We need to conduct the study to influence formulation of policies in the country. 'Through such studies, we'll know to a certain extent their needs and the percentage of their contributions to the country." (Retrieved from The Straits Times Interactive, April 20, 2003, http://straitstimes.asia1.com.sg).

The multiple levels of perceptions in Chapter 7 illustrate the fluid nature of work. Because perceptions are based on context (person and situation), *Dai*s' ambivalent feelings towards their work are not contradictory, but rather are a reflection of the social value of their work. The contradictions that have emerged are found at two levels. First, despite delivery work being an alternative route for income generation, *Dai*s do not perceive it as such, although it is work to which many of them resort when they cannot find any other employment. Second, even though *Dai*s' delivery health services are essential, and community members acknowledge this, they continue to devalue *Dai*s' contributions. The sociocultural framework enables both groups to accommodate two contradictory views about *Dai*s' work, but the framework is not advantageous to *Dai*s. Under this framework, *Dai*s do not use statistical data to support their work. They use varied cultural descriptors that are more fluid to describe their work. The authority of biomedicine lies on uniformity of data, which allows for standardisation. Future research could explore whether *Dai*s' work would continue to have the same low value or whether it would assume similar stature to that of biomedicine if *Dai*s' work were to be stripped of the sociocultural connotations and standardised.

The HFA legitimised the Government of Gujarat (GOG) and the GOI's move to involve the indigenous midwives. *Dai*s' participation came under the aegis of community participation as a response to bridge the gap in the health care system. However, what was not stated is that community initiatives could lead to governments offloading their responsibilities to provide the common good—health care. Offloading has serious implications for populations that are already marginalised. Certainly the *Dai*s in Gujarat have experienced some form of offloading. They have been made to assume certain health care functions without any formal agreement or recognition by the state government. This lack of formal contract has placed them in an unusual position. On the one hand, it has given them the legitimacy to work in the formal health care system. On the other hand, it has led to the devaluation of their contributions. Their work is not accounted for in the overall GDP nor are the savings to the health care system known. The Rs. 20 is a token payment to acknowledge *Dai*s' involvement, but it is not a true reflection of their work. The unequal relationship between *Dai*s and the Gujarat government shows that community participation is not equitable, and its intent to empower is not realistic. Instead community participation enables a dominant group to determine the direction of the relationship. Indeed, community participation has provided the Gujarat government and others with a convenient label to categorise *Dai*s' contributions as unpaid and informal work, thus propagating the idea of *Dai*s' work as helping and temporary.

Exploring work as a social construct (Chapter 8) instead of purely economic provides an added dimension for understanding human resource development. SEWA's involvement with *Dai*s through its various initiatives to promote their work and to bring about changes in the economic and social realms offers a good contrast to the Gujarat government's efforts. It is not because it is a women's organisation (although this is critical), but because its leadership and membership roles are occupied by poor women. Although there are women from the middle class in administrative positions, the organisational set-up is such that poor women are the ones who decide the strategies to enhance their socioeconomic condition. The difference in approach between the government and SEWA lies in the emphasis and a consultation process. Unlike the government's approach where strategies are usually formulated at the top with very little input from poor women, SEWA's work begins with placing women's needs at the centre. One reason for the barrier to consultations could be related to the organisational structure. The government by its nature is a huge bureaucracy, which at times makes decentralisation difficult. Compared to the Gujarat government, SEWA is a small NGO that allows for flexibility and decentralisation. Because SEWA's members are often shut out from the mainstream decision-making process, the structure of SEWA is such that women have access through various channels to make their wishes and problems known to the top. This flexibility ensures that women from all levels are heard and become visible.

A second difference between SEWA's and the Gujarat government's approaches to human resource development lies in SEWA's ability to look beyond the usual markers in identifying women leaders. The organisation recognises that women possess potentials despite their poverty and lack of literacy. SEWA's mobilisation of women is similar to Freire's idea of conscientisation, in which women such as *Dai*s are assisted to look critically at their own knowledge and situation and use that awareness as the starting point to bring about changes. SEWA calls this awareness and the ability to initiate changes *capacity building*. SEWA is aware of the cultural and social underpinnings of birth and delivery. However, it is attempting to correct this images that devalue *Dai*s's work and create some form of level playing field for *Dai*s. These are manifested through various income-generating (*Dai* co-operatives and the operation of primary health clinics) and social-enhancement (ID cards and *Dai* School) schemes. The long-term goal is to alleviate the devaluation of *Dai*s' work and bring about social changes in the community. In summary, SEWA's initiatives differ from the Gujarat government's in one fundamental way: SEWA views *Dai*s as an important resource that should be strengthened, whereas Gujarat health officials perceive *Dai*s' presence as a sign of weakness and as something that eventually needs to be phased out. Certain key elements are found in all of SEWA's development work with *Dai*s. These include ensuring that they have reliable income and work, enjoy good health, and achieve self-reliance. These elements are absent for *Dai*s in the Gujarat government's multiple development schemes.

Understanding the influence of authoritative perception on work means that the gap in the literature on *Dai*s' work and training has narrowed. The lack of information has not served *Dai*s well because it has prevented them from mobilising earlier to demand a more equitable relationship with government and other stakeholders. Work as a social construct has exposed the fallacy that work is purely an economic input with its monetary value based on a set of objective and measurable markers. If the monetary value of work were based on objective measurements, it would follow that that same input would command the same price regardless of who is performing the action. However, the same delivery work performed by *Dai*s is valued lower than that of female health workers (FHWs) and physicians. Each group is paid according to what society perceives as of greater prestige, which is determined by caste, class, gender, education, and power. The prestige of biomedicine allows those who are part of the establishment to create artificial supply and demand of health services and health policies.

Finally, work and skill (types and levels) are socially and politically defined and are subject to change. Labels such as informal/formal, paid/unpaid, and skilled/unskilled shift to meet the needs of the overall health or economic system, something that is seen in connection with *Dai*s' work. *Dai*s are aware that being identified with symbols of the biomedical establishment could accord them prestige because society identifies these symbols with skills and knowledge and values them highly. Although *Dai*s are skilled birth attendants, their need to possess biomedical symbols appears to align with the objectives of the influential biomedical establishment, and that is to equip these women with what it perceives to be legitimate knowledge and skills and change their practice accordingly. It appears that *Dais* are beginning to be aware of the link between level of income and the public's perceptions of their work, and the potential advantages of aligning with biomedicine. However, what is unknown is the long-term effect of this alignment on *Dais*. Some of the possible scenarios include tensions between the government's national interests and the *Dais*' need for equitable income. Because SEWA is challenging the existing power structure, conscientised *Dais* could demand equitable wages and other social benefits from the government. Conflict could also arise between *Dais*' need for income and clients' inability to pay. *Dais* may not be seen as an alternative if their services do not meet the needs of the population.

However, in-depth examination of *Dais*' work indicates that it is not enough to be involved in work. The type of work, the level of remuneration to meet the basic needs (and beyond), and the perception that the work is socially desirable are all important factors for consideration. SEWA is addressing these issues to change the negative images of *Dais*' work at the sociocultural level. It is promoting the idea that indigenous midwifery should be considered as an independent, stand-alone profession instead of being subsumed under the biomedical establishment. Thus SEWA's intersections are critical for building *Dais*' capacity. Its economic initiatives fall within the RCH framework where it addresses women's health through the development of human resources.

In summary, both the Gujarat government and the SEWA organisation understand that grinding poverty is at the heart of all ill health; however, their approaches to address poverty and its causes differ. SEWA knows that the multiple economic niches that women create are key to their survival. Its work with self-employed women in the informal sector shows that these economic niches provide women with a source of income in an environment of high under- and unemployment. SEWA knows that unless women have secure income and work, they will continue to suffer ill health. That is why it continues to support *Dais* in their work. However, as noted, SEWA's development work is multi-pronged. Through its economic initiatives it has attempted to mobilise women politically and to address gender bias and patriarchy. The Gujarat government has also created multiple development schemes to address poverty. But these are not integrated, and, unfortunately, they remain inaccessible to women, especially those who need it most. Lack of transparency of the schemes, gender bias, and the authoritative nature of the government intimidates women (especially women in the margins). All of these things do not encourage women to come forward.

Future Developments: Implications for policies

Knowing that policies intended to benefit a particular group can also have adverse effect on them means being cognisant about future policy formulations. Although the disadvantage of policies that are broad is noted, at the same time, these policies would allow flexibility to accommodate future changes. Some of the suggestions that have emerged from this study are as follows:

- Develop more comprehensive and appropriate registration information to capture and honour *Dai*s' previous work experience and knowledge without further marginalising them.[189] Policies to mainstream *Dai*s have to ensure that strategies implemented value their informal learning. One such strategy would be to develop prior learning assessment. Similar strategy was implemented and carried out in Alberta where midwives who were already practising wrote an exam to evaluate their prior knowledge during the pre-licensing stage. By acknowledging their informal learning, steps could be taken to credit *Dai*s for their past learning when they enter formal learning or the health care structure. At the present time, despite attending workshops and observing techniques in various settings, there is still a perception that *Dai*s' are not skilled or knowledgeable.
- Build *Dai*s' capacity as workers and women. One way could be to include *Dai*s in the consultation process when developing examination package for credentialisation. This shows respect for them as health workers, for their contributions and indicates that they have equal stake in the health care.

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[189] In a recent article in the Alberta RN, titled *AARN Staff Learn More About Cultural Diversity*, there is a move by the AARN to develop a culturally appropriate framework that would allow internationally qualified nurses to understand the AARN licensure process. The article noted that workshops for staff are "designed to develop greater sensitivity and enhanced awareness of cultural diversity. These skills will enable the AARN staff to review existing registration policies, procedures and practices to identify and begin to address barriers to licensure access" (Alberta RN, 2003, p. 18). Indeed a study quoted in the article indicated that 70 to 80 per cent of the 300 members of Alberta Association of Domestic Workers are unlicensed foreign qualified nurses seeking AARN registration. Some of the challenges these applicants experienced include English language assessment difficulties, a lack of knowledge of the role of the nurse within the Canadian health care system and the cultural differences between Canada and their country of origin (Alberta RN, 2003).

- Formulate a wage framework that would recognise and compensate *Dai*s for the less than optimal conditions they work in. For example, those who work in the formal sector are paid higher wages when working either in less than optimal environments or in occupations that are not considered desirable. Similarly, *Dai*s' level of remuneration should reflect that they provide essential services even though the work they do is considered undesirable. A wage framework that compensates them would ensure that *Dai*s do not suffer from the effects of inadequate or irregular income.
- Current perceptions that imply that *Dai*s are incapable should be amended.

Final Reflections

I began my dissertation with the personal voice and I would like to conclude the same way. As I write my dissertation, various images flit through my mind about my experiences in the field and the knowledge that I gained about women's work. I realised that women's work is complex and fluid. The double-burden they experience is not just a catch phrase but it is real. Women have to juggle so many tasks to meet the needs and expectations of their families and community. At the same time, women have to balance their own aspirations and learn to define who they are and their own needs. They constantly have to do the balancing act between what they want and what is expected of them. In some ways, my own experiences during the fieldwork reflect the same balancing act – maintaining a fine balance between what I went with and what I was able to achieve and the ability to let go if it was not possible to do. This is not to say that I compromised my research but I learned a very important lesson of knowing when to formulate different strategies to gain the same information. I learned to be flexible. I also learned to ask questions such as, "Why am I using this method/technique? Can the same questions be answered in a different way? Is the answer already there and I am not able to discern it? Is the answer to this question essential to my research? Who else could assist me if the particular individual is not available?"

The decision to use multiple perceptions to explore *Dai*s' work was critical and needed for two reasons. First, the emergence of a conceptual framework of authoritative perception that provided a starting point to question previous images and understand *Dai*s' socioeconomic situation. Second, it enabled the inclusion of information excluded in the past to counteract the stereotypes that *Dai*s have come to be associated with. The findings and the discussion using the multiple perceptions clearly show the danger of using one perspective regardless of whose perspective it is. Understanding the influential role of authoritative perception means that all of us have to be aware of the need to question accepted truths and images. Sometimes views stated may not reflect the reality of those for whom it is purported to represent.

The study that is being carried out in Malaysia (mentioned earlier) could enhance my findings, particularly the value of women's housework. Indeed, future research that would put a dollar value on *Dai*s' work would be valuable. This would further strengthen my findings and provide evidence that would dispel the perception that *Dai*s' work is peripheral. The data would show *Dai*s' contributions to the economy, the savings to the health care system, the double burden they experience of doing work both in the house and outside and the need to match *Dai*s' work with equitable wages and other social benefits that formal workers are entitled and receive.

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APPENDIX A

SEWA'S LETTER OF SUPPORT

સ્વાશ્રયી મહિલા સેવા સંઘ
SELF EMPLOYED WOMEN'S ASSOCIATION (SEWA)
Sewa Reception Centre,

Phone :

TO WHOM IT MAY CONCERN

SEWA has invited Ms.Subhadra Devi Rai, a phd student of University of Alberta, Canada, to undertake her research work with us. We have mutually agreed on her working on examinig SEWA's community health programme and its impact on women's work and empowerment.

We welcome the opportunity to work with Ms.Subhadra Rai who will be affiliated to SEWA during her time in India.

IN . Sincerely,

[Mirai Chatterjee]
General Secretary

પ્રધાનમંત્રી : મીરાઇ ચેટરજી
General Secretary : MIRAI CHATTERJEE

સ્થાપક : ઇલા આર. ભટ્ટ
Founder : ELA R. BHATT

APPENDIX B

GOVERNMENT OF INDIA LETTER OF SUPPORT

No.F.12-52/98-U.4
Government of India
Ministry of Human Resource Development
Department of Education

Dated : 9.11.1998

The Administrative Director,
Shastri Indo-Canadian Institute,

Subject :-Approval of Research Project entitled, " A critical evaluation of SEWA's social organisations :Implications for women's and community health" to be undertaken by Ms Subhadra D.Rai, a Singaporean national for a period of twelve months in affiliation with Self Employed Women's Association, Ahmedabad.

Sir,

I am directed to refer to your letter dated May 19, 1998 on the subject noted above and to convey the approval of the Government of India to the above research project, subject to the following conditions:-

i) submission of detailed itinerary (in triplicate) giving exact dates, duration and places likely to be visited by the scholar during her stay in India, together with request for visa authorisation;

ii) during the period of research, the scholar will not engage in;

  (a) political activities

  (b) activities prejudicial to the interests of the host country.

  (c) activities which could be embarrassing to the relations between the host country and any foreign country ; and

iii) the scholar would not be allowed to visit any restricted/protected/prohibited/tribal areas in the country in connection with her research project.

Yours faithfully,

A.C.AGNIHOTRI,
FOR Deputy Secretary to the Govt. of India

APPENDIX C

SHASTRI INDO CANADIAN LETTER OF INTRODUCTION

Shastri Indo-Canadian Institute
INDIA OFFICE

22 March, 1999

TO WHOM IT MAY CONCERN

The Shastri Indo-Canadian Institute was formally established in August 1968 by joint announcement of the Governments of India and Canada. The programmes of the Institute in India are funded by annual Rupee grants from the Government of India received through the Department of Education, Ministry of Human Resource Development, New Delhi.

Dr. Subhadra D. Rai has been awarded Women and Development Fellowship by the Institute to do research on **"A critical evaluation of SEWA's social organisations: Implications for women's and community health"**. Her application has been approved by the Department of Education, Ministry of Human Resource Development, Government of India vide their letter No. F.12-52/98-U.4 dated 09 November, 1998. Dr. Rai has been affiliated with Self Employed Women's Association, Ahmedabad. Any academic facilities and courtesies that may be extended to her will be greatly appreciated by us.

M.K. Lakhtakia
Administrative Director

APPENDIX D

SEWA LETTER OF INTRODUCTION

સ્વાશ્રયી મહિલા સેવા સંઘ

SELF EMPLOYED WOMEN'S ASSOCIATION (SEWA)

Sewa Reception Centre, Opp.
Phone
Email

Date : May 25, 1999

To Whom this May Concern

I am writing to introduce Ms.Subhadra D.Rai who is working with SEWA this year. I request you to give her an appointment to interview you at your convenience.

Ms.Rai is a graduate student from the Department of Public Health Sciences, Faculty of Medicine at the University of Alberta, Canada. She is conducting her Ph.D research entitled, "A Critical Evaluation of SEWA's Health Organisation : Implications for Women's and Community Health," in which she will focus or Dais work in Gujarat.

Ms.Rai's research in India has been made possible through a "Women and Development" Fellowship grant awarded by the Shastri Indo-Canadian Institute, a joint venture of the governments of India and Canada.

Ms.Rai's application has been approved by the Department of Education, Ministry of Human Resource Development, Government of India (letter no.F.12-52/98-U.4 dated November 9, 1998.) She will be here till December 16, 1999.

I would appreciate if you would give Ms.Rai some of your time and guidance at your earliest convenience.

Thank you.

Yours Sincerely,

Ms.Mirai Chatterjee
General Secretary
SEWA

APPENDIX E

PARTICIPANTS AND METHODS USED IN GUJARAT, INDIA, FROM APRIL 1999 TO JANUARY 2000

Table E1

Participants and Methods Used in Gujarat, India, from April 1999 to January 2000

Site	Focus group	Personal interviews	Surveys
Site j **(Mehsana)** Total: 3		PHC staff (3)*: 1 MO, 1 FHS, 1 FHW	**27 urban *Dais* in Ahmedabad City** (14 non-SEWA and 13 SEWA)
Site n **(Mehsana)** Total: 24		VDG (7): 2 *Aganwadi* workers, 1 teacher, 1 principal, 1 *talati*, 1 water operator, 1 Deputy *Sarpanch* PHC Staff (5): 1 MO, 1 FHS, 2 FHWs, 1 MPW *Dais* (3): 2 non-SEWA and 1 SEWA *Dais*' family members (3) *Dais*' clients (6)	**68 rural *Dais* in Mehsana District** (35 non-SEWA and 33 SEWA)
Site a **(Mehsana)** Total: 13	VDG (4): 1 *sarpanch*, 1 *talati*, 1 teacher, 1 *Aganwadi*	PHC staff (5): 1 MO, 1 FHS, 3 FHWs *Dai*: 1 SEWA *Dai*'s family member (1) *Dai*'s clients (2)	
Site m **(Mehsana)** Total: 8	VDG (3): 1 *sarpanch*, 1 teacher, 1 water operator	PHC staff (5): 1 MO, 1 FHS, 3 FHWs	
Site d **(Mehsana)** Total: 17	PHC Staff (5): 1 FHS, 4 FHWs	PHC staff (1): 1 MO VDG (7): 1 Deputy *Sarpanch*, 2 *Aganwadi* workers, 1 teacher/principal, 1 *talati*, 1 water operator, 1 nonresident Indian man *Dai*: 1 non-SEWA *Dai*'s family member (1) *Dai*'s clients (2)	
Site v **(Mehsana)** Total: 13	VDG (6): 1 *sarpanch*, 2 *Mahila* members, 1 teacher, 1 *talati*, 1 *Aganwadi* worker PHC Staff: (3): 1 MO, 2 FHWs	*Dai*: 1 SEWA *Dai*'s clients (2) *Dai*'s family member (1)	

(table continues)

Other participants	Focus group	Personal interviews	Participant observation
SEWA members Total: 29	SEWA researchers (7) SEWA Community Health Workers (7) SEWA Health Supervisors (4)	SEWA leaders (6) Mirai Mittal SEWA insurance coordinator (1) SEWA occupational health coordinator (1) Chandabehn	• Birth at home (rural) • Birth at a PHC (rural) • C-section at an urban hospital (Ahd. City) • Labour ward and post-delivery care Unit (Ahd. City) • PHC infrastructure, living at PHCs in Mehsana • Urban health infrastructure (PPU, maternity units, hospital) • Slums • Villages
Other participants Total: 16 (excludes the participants of informal focus groups)	Three informal focus groups of Ahmedabad City Health Workers of post-partum units and maternity clinics (3 MOs and 7 FHWs) (Approx. 3-5 participants in each group)	UN: UNDP (1), UNFPA (1), UNICEF (1) World Bank (1) Gujarat Health Minister Gujarat State Health Officials (2) State Research Director (1) NGO staff (1) MO, FPAI (1) CDHO (Mehsana) (1) Ahd. Municipal Corp Officials (2) Ahmedabad. District Official (1) Retired Health Official (1) Nurse tutor, SIHFW (1)	

* Numbers in parentheses denote number of individuals.

Total participants interviewed both in focus groups and personal interviews: 117
Total *Dais* surveyed: 95

APPENDIX F

DAI SURVEY FORM

Dai Survey Form

Understanding *Dais*' Work Experience and Knowledge—A Ph.D. Research

Dais Personal History:
Name: ______________________________ Age: ______________
Caste: ______________________________ Religion: ______________

Marital status: Never married; married; separated; divorced; deserted; widowed. Is this your first marriage? Yes/No
Age of marriage: ____________

Education: (a) Formal learning: ______________________
(b) Informal learning: ______________________

Address: District: ____________; Taluka: ____________; Village: __________
City: ______________
Full address: ____
____

Family history: (a) Husband
Age: ________ Age of marriage: ________ Work: ______________
Is this your first marriage? Yes/No

(b) Children
Total deliveries: __________ First delivery: Age ______; Year: ______
Last delivery: Age ______; Year: ______
Number of stillborn: __________
Livebirths (but died soon after): ________________ (see below for history)

Number	1	2	3	4	5	6
Male/Female						
Age						

Abortions: Induced and spontaneous

Spontaneous Induced
(a) Miscarriage: ______; (b) medications: ______; (c) Hospital: ______;
(d) Home remedies: ____________

Induced or Spontaneous

Female: ______; Reason: ______________________________
How many times: ______________________________

Male: ______; Reason: ______________________________
How many times: ______________________________

Children's History

Boy(1) Girl (2)	Current age	Trade, informal training/ work	Marital status	Age of marriage	Living with you: Yes/No

Dai's view regarding family planning (FP)

As a *Dai*, do you advise women to use contraceptives? If yes, which method and why? ________

If no, ____, why not? ____________________

(A) _Dai_'s work history and training

Are you working as a *Dai* at the present time? Yes/No (why): ____________________
How long have you been working as a *Dai*? (mths/years): ____________________
At what age did you begin working as a *Dai*? ____________________
Please describe your work: ____________________

On average, how many deliveries do you conduct per year/mth? ____________________
Are they usually from your village? Yes/No ____________
If no, where else do you go? ____________________
How far are these villages/slums? Distance: Km/mile/furlong: ____________________

Do you feel pressured to work as a *Dai*? Yes/No. What kind of pressure do you experience?

Types of Health Facilities Found in Your Area

Area	Government health centres/dispensaries	Visits by doctors and nurses	Private hospitals, clinics/dispensaries	Others (Trust voluntary organisations
Village/city/ slum				
Taluka				
District				

Do you have access to transportation (type)? Yes/No ______________________________
If yes, who provides the transportation? ______________________________
If no, what do you do? ______________________________

Is it unsafe to go out at night? Yes/No. If yes, what do you do? ____________________
____
____

What is your opinion regarding hospital births? ______________________________
____
____

What is your experience at hospital? ______________________________
____
____
____

When you are busy with other work or engaged in other delivery, do you ask another *Dai* to help you? If yes, how? ______________________________
____

If no, why not? ______________________________
____
____

What other work do you do? ______________________________

Who pays for your delivery work? ______________________________

Types of payment? Money/grains/vessels/cloth(es)/ ornaments/others ____________________
Are you satisfied with the payment? Yes/No. Why? ______________________________
____
____

Do you receive any other benefits from *Dai*'s work? Please explain. ____________________

The remuneration you receive from *Dai*'s work, is it important to your family's expenditure? Yes/No: __________. If yes, how is it important? ____________________

If no, how do you manage your household expenses? ____________________

What other assets do you have? ____________________

Payment

Birth / individuals	Government	Family	Others
Birth of a girl child			
Birth of a boy child			

Do you think there should be a change in government's remuneration? Yes/No. Please explain how? ____________________

Do you want to see a change in the way family pays you? Yes/No. Please explain how? ______

(B) *Dai*'s initial apprenticeship

At what age did you begin your *Dai* apprenticeship? ____________________
Who taught you *Dai*'s work? ____________________
How were you taught? ____________________

How long was your apprenticeship? ____________________

Did you learn delivery work at your natal village? Yes/No **OR**
Did you learn delivery work in the village you are living now? Yes/No

(a) How did you come to live in this village? ____________________

(b) How long have you been a resident of this village? ____________________

Table F1
Number of Training Sessions Attended

Structure	Yes/No	No. of times attended	Year/season last attended training	Time: a.m./p.m.	Place	Convenient		How many sessions did you attend in each training (out of the total)?	Were you present for the entire session? Yes/no
						Time Yes/No	Place Yes/No		
Government									
SEWA									
Other institution									

Table F2
*Dai*s' Training/Apprenticeship History

Structure	What did you learn from the training?	Was there a test after the training? Yes/No	How was the test conducted?	Did you receive any instruments after the training? Yes/No	How often were the instruments replaced?
Initial apprenticeships					
Government					
SEWA					
Other institution					

Table F3

Impact of Training on *Dais*' Work

Organisation	Impact of training-any change on your work? Yes/No	Level of knowledge ↑↓O	Number of clients coming to you ↑↓O	Level of respect by doctors/nurses ↑↓O	Level of respect by villagers ↑↓O	Fees ↑↓O	Feedback regarding training				
							Very good	Good	Fair	No comment	Unsatisfactory
Government											
SEWA											
Other Institution											
Please explain											

↑-Increase; ↓-decrease; 0-no effect/no change

Table F4

Based on Your Experiences, What Suggestions Can You Give to Improve the Training

Structure	Format	Knowledge and information	Length of training	Frequency of training	Other suggestions
Government					
SEWA					
Other institution					

Information regarding SEWA membership

Are you a member of SEWA? Yes _________ since 19____
Why did you become a member?

If you are not a SEWA member, why not?

Are you a member of a *Dai* cooperative? Yes _______ since 19_____
Reasons for joining the cooperative:

If no, why not?

Any other suggestions?

Thank you for participating in the survey.

Objectives of the Survey

- To identify SEWA and non-SEWA *Dai*s.
- To understand *Dai*s' beliefs and perceptions regarding women's health.
- To identify *Dai*s' skills and knowledge about reproductive health.
- To identify *Dai*s' workload in rural and urban areas.
- To ascertain *Dai*s' perceptions regarding the training programmes provided by various institutions/organisations.
- To identify the constraints under which the *Dai*s work.

APPENDIX G

STEPS TAKEN IN THE FORMULATION OF THE SURVEY FORM

Survey Questions

- **Initial draft:** The survey questions was formulated by me (the researcher) and then distributed to a number of individuals who were either connected with the research, both in SEWA and outside and those who were not (again in SEWA and outside). The purpose was to elicit feedback on the questions.
- **Feedback on the initial draft:** (1) The questionnaire is long (7 pages); (2) Certain topics on reproductive history may be taboo or too personal for the *Dais*; (3) There should be some direct questions on *Dais*' work, and on referral system used by the *Dais*.
  Once the responses were collated, the **content** and the format of the survey questionnaire were reorganised to include questions on *Dais*' work; however, these questions were open-ended so as not to lead the *Dais*. By asking open-ended questions, I wanted to explore *Dai*s' work, that is, **what they do** instead of me indirectly informing of **they should do** through the questions. Reformatting of question was done by combining tables or removing questions that basically asked for the same answers. Despite the changes, the questionnaire still came to be 7 pages.
- **Second draft:** The questionnaire was given to Mirai. Her feedback was favourable except the section on *Dai*'s reproductive history-she suggested that these questions could either be asked in a focus group or in an interview. I was unable to discuss this issue further with her as she left for her holidays the next day. And when she returned, I broached the subject again, and she indicated that she 'felt uncomfortable' but suggested that I should begin the translation of the questionnaire (she left the next day for Kutch due to the cyclone).
- **Translation of questionnaire:** This took 5 days and was done with the assistance with a linguist. I sat with during the process. We would discuss the question and ensure that the Gujarati translation closely adhered to the English version. The questions were further refined during the translation process. Once the survey questions were translated and typed into Gujarati, it was given to SEWA's Health Coordinator (Mittal) and Chair (Mirai) for review. They still had concerns about the questions pertaining to *Dais*' reproductive history and questions regarding *Dai*s' thoughts on marriage, re-marriage and widowhood. Other questions included the impact of *Dai*s' changed marital status and their standing in the community. Both Mirai and Mittal felt that these questions could be asked in a qualitative interview and not in a survey. They were concerned about the effect these questions would have on the *Dai*s. Some of their concerns were: (1) the well-being of the *Dai*s; (2) *Dais* may feel offended as the questions were personal; (3) *Dai*s may be uncomfortable because many of these questions are not openly discussed. I felt that these questions could have provided a glimpse of the biases that *Dai*s may have that influence their work, but I understood both Mirai's and Mittal's concerns. They have worked with the *Dai*s and understood the cultural nuances of women in a South Asian society. The questions, however, reflected my biases. Although I am of South Asian descent, at the time when I formulated these personal questions, I was operating from a North American mindset. I felt that such questions needed to be asked because by not asking them, we are reinforcing the culture of silence and shame. Bringing these questions out in the open could provide an avenue for forum for discussion for women.
- **Third draft:** The questions that were "uncomfortable" for SEWA or considered offensive to the *Dais* were removed from the survey. The revised questionnaire was given to Mirai and Mittal. This questionnaire was used for the pilot-testing.
- **Pilot-testing the questionnaire:** Two researchers from the Health Cooperative assisted me in this process. I discussed with them and they felt that 8 *Dais* would provide me with enough data to ascertain if the questions in the survey needed to be changed before the actual survey began. The questionnaire was pilot tested in Ahmedabad District (Dholka and

Sanand) and in Ahmedabad City (Saraspur) over a period of 2 days. In total 8 *Dai*s were involved in the pilot-testing. Each interview session was taped in entirety and were used to refine the questionnaire. Some of the issues that arose were: (1) clarity of questions; (2) ensuring that both recorders/interviewers understood the meaning and the purpose of the questions; (3) interviewer fatigue; (4) having adequate time to complete the survey forms. During this meeting the two interviewers and I discussed each question and I sought their understanding of each question (at this time we were using the Gujarati translated questionnaire) and explained my reasons in formulating each question. Based on our findings from the pilot-test, further changes were done on the survey form. Other issues that arose was ensuring that the *Dai*s did not have to wait, or if it was inconvenient for them to come to a central location, then I would go to their homes to interview them. In this way, they would be able to continue with their work. Some of the changes that were made to the survey form are:

(1) The title of the questionnaire from "Survey Questions" to "Understanding *Dais*' work experience and knowledge- A Ph.D. Research."

(2) The title of the section where we ask *Dais* whether they give advise on family planning and what are the advice they give on pg.2.

(3) The question following this title because originally this question came after the questions about *Dai*'s reproductive history on pg. 2.

(4) Adding another column titled "others" under the box that asked for the various facilities that are available in their districts, villages and blocks on pg.3.

(5) Splitting the question regarding the availability of vehicle/transportation into two on pg.3.

(6) Adding another title and making the difference clear between payment in cash and in-kind clearer on pg. 3.

(7) Deleting the question about how much money/cash they receive for each delivery because this question is already covered in the box on pg. 4 that asks what the *Dais* receive when they deliver a male and female child from govt., family and others.

(8) The question regarding payment from the box was further refined into whether the *Dais* are satisfied with that they receive from the govt. and the families and the reasons for their satisfaction/dissatisfaction. This is on pg. 4.

(9) On pg. 4, the title regarding *Dais* initial training was changed. In Gujarati, there are two words for training. These are *taleem* and *sikhya*. *Taleem* implies a more formal learning especially through the government structures whereas *sikhya* means learning through observations and apprenticeship. This change was done because I wanted to understand what they had learned in their initial training as compared to their 'training and learning' through the biomedical structures. These words enabled the *Dais* to distinguish between the government training and apprenticeship.

(10) Placing the title "levels of satisfaction" above the grading question on pg. 6, and placing the symbols (↑,↓, and 0 to indicate increase, decrease, and no effect for questions regarding the effect of training on their practice, knowledge, trust by the biomedical staff, villagers, and clients' families, number of clients, and payment.

- The **fourth draft** of the survey form was the final questionnaire that was used in this research (Appendix B).

On 14/6/99, I updated both Mirai and Mittal of my progress and discussed the shift in focus for my research. Instead of focussing on two rural areas, I would conduct my research to include both rural and urban areas. The rural setting was Mehsana District (10 villages) where SEWA *Dais* were found and the urban area was Ahmedabad City. I began my survey on 21/6/99. During this meeting I provided Mirai and Mittal with a copy of my research time schedule and discussed the outcomes and the difficulties encountered during the pilot test. I also requested for a complete list of SEWA *Dais* in Mehsana and Ahmedabad City by 18/6/99.

15/6/99: In the meantime, I reviewed the pilot-testing process with two interviewers. We compared the written results in the questionnaire with the taped version. The purpose of this exercise was to ascertain (a) which data had been excluded/included due to recorder's interpretation; (b) which information should be included and excluded; (c) the dialect of the *Dais* and the difficulty of keeping up with her; and (d) repetition of information. Other discussions included the sections that would be taped during the actual survey, including obtaining and taping of the verbal consent, *Dai*s' work experience, and their personal data. The taping of the personal data was important as there could be more than one *Dai* with same names. Having taped data would assist us to review the information if needed.

APPENDIX H

CONFIDENTIALITY AGREEMENT

Confidentiality Agreement

I, ______________________ ______________ understand that all information obtained during the interviews are strictly confidential. My role as an interpreter/transcriber is to ensure that the interpretations/transcriptions are done accurately and kept closely to the original meanings of the participant (s) interviews. I understand that I will not divulge any segments of the interview data (either in part or in entirety) to anyone both during and after the research has completed. I understand that to do this would be a violation of my contract with the researcher and the "subjects" of the research and constitute a breach of trust. I also understand that a breach of trust on my part may have negative repercussions to some participants in the research.

Name: (Print)_________________________________ Date:______________________

Signature:_________________________________

Interpreter/Transcriber

Name: (Print)_________________________________ Date:______________________

Signature:_________________________________

Interpreter/Transcriber

Name: (Print)_________________________________ Date:______________________

Signature:_________________________________

Researcher.

APPENDIX I

INTERVIEW QUESTIONS

Interview Questions

International Agencies and India's RCH Programmes

1. Please tell me about yourself.
2. How does your organisation define health?
3. How have this/these definition(s) influenced your organisation's approach to RCH?
4. How have this/these definition(s) guided your organisation's work with India in its RCH programmes?
5. What are some of the ways your organisation is collaborating with India in its RCH programmes? This could be either through:
    - Funding
    - Providing technical advice
    - Other avenues and linkages
6. What are some of the criteria that your organisation has used to disburse funds for RCH?
7. In your opinion, what is the economic, social and health impact of RCH on India?
8. Has your organisation made any projections of the expected/potential outcomes based on the above? If yes, what are some of the findings?
9. I am interested in learning about the work of *Dai*s.
    - Has your organisation work with *Dai*s in the past? If yes, in what capacity?
    - What were the outcomes of this link?
    - In addition to above, what other linkages do your organisation have with *Dai*s?
10. Has your organisation's policy about *Dai*s changed especially in the context of RCH?
11. I am interested in learning about *Dai*s and RCH framework.
    - Do you think *Dai*s have a role in RCH?
    - If yes, what are some of the roles that you see *Dai*s playing in RCH? (If no, ask why?).
    - Do you think *Dai*s' role will change in future? If yes, how and why? If no, why?
12. Are there any questions that you think I should have asked but did not? Any other comments or views?

Thank you for participating in this interview.

Health Trainers and Supervisors: Gujarat and SEWA

1. Please tell me about yourself.
2. How do you define health based on your work and experience?
3. What changes have you seen in regards to health in the past few years in regards to:
    - General health level in rural and urban areas.
    - Women's health in rural and urban regions
4. What are some of the emerging health issues that you see in the above categories?

Since I am interested in exploring the linkages between work and health and knowledge, I would like to know the following:

5. How do you identify a *Dai*?
6. What criteria do you use to ascertain the level of skills and knowledge of *Dai*s? Have these criteria been useful? Yes – how? If no, why not? What have been your experiences?
7. What were the goals and objectives for starting *Dai* training in India/Gujarat/SEWA?
8. Have these original goals and objectives been achieved thus far?
9. In your opinion, what were some of the reasons that prevented the realisation of these objectives?
10. What are the criteria used when selecting *Dai*s for training?
    (a) What are the **advantages** of *Dai* training on:
    - Women's health
    - Health care system
    - *Dai*s

    (b) What are the **disadvantages** of *Dai* training on:
    - (Refer to the above groups).
11. What are some of the obstacles that you have encountered when training *Dai*s?
12. Have these barriers been addressed? If yes, how? If not, why not?
13. Is the government aware of these barriers? Please tell me what has been the outcome when it became aware?
14. Presently, are there any *Dai* training being conducted in Gujarat/or by SEWA?
15. What are some of the factors that have led to *Dai* training? Are these factors similar to the original goals and objectives?
16. How often are these training held? Who conducts the training? What is the duration of each of the training session?
17. Apart from the training sessions, are there any refresher courses for *Dai*s?
    - How often are these refresher courses conducted?
    - What is the duration of each refresher course?
    - Is the attendance to the refresher courses based on *Dai*s ' years of experience or previous training?
    - Are *Dai*s paid when they attend the refresher classes?
18. How is the *Dai* training session evaluated in the past and now? **Ask why if there has been a change in the method of evaluation**
19. What are the plans for the future in regards to *Dai* training and refreshers?

20. Based on your observations and experiences, what feedback have you received regarding *Dai* training from the following groups:
    - Staff of Primary Health Center
    - Villagers and community leaders
    - *Dais*' clients
    - *Dais* and their families
    - Others
21. Remuneration:
    - What criteria were used to set the rate of payment for *Dais*?
    - What were the objectives to pay *Dais*?
    - Have these objectives been achieved? If yes, how? If not, why not?
22. Identity cards:
    - What were the goals and objectives of issuing identity cards to *Dais*?
    - What is the role of the identity card on *Dais*' work and remuneration?
23. *Dai* Delivery Kit (DDK):
    - Please tell me some of the reasons for the giving DDK to *Dais*?
    - In your opinion, is the DDK useful to the *Dais*? If yes, how?
    - What has been the impact of issuing DDK to *Dais*? Please give some examples.
24. *Dais*' contributions to the health care system
    - What role do you/do not see *Dais* playing in the health care system, especially in RCH framework?
    - Do you think that *Dais* will be around in the future? Please elaborate your answer.
25. Are there any questions that you think I should have asked but did not? Any other comments or views?

Thank you for participating in this interview.

Minister of Health, Commissioner of Health and Additional Director of Health and Family Welfare

1. Please tell me about yourself.
2. What are some of the challenges that you encounter when:
   - Formulating or implementing new health policies
   - Mobilising resources to implement these health initiatives.
3. How do you balance the need for new health policies and expenditure?
4. How do you ensure that the implementation of new health policies complement the existing ones?

Because I am interested to learn the impact of RCH framework on Gujarat, I would like to know the following:

5. When did RCH policies come into effect in Gujarat?
6. What is your ministry interpretation of RCH?
7. How is RCH different from the previous MCH and CSSM?
8. In what way will RCH framework impact the existing policies related to women's health in India and Gujarat?
9. Has your ministry made any tentative projections about the impact of RCH on women's health?
10. How will the answers to the above (7) and (8) affect future funding and programming?

Since 60% of births in India are conducted at home, and Dais conduct the majority of the births, I would like to know the following:

11. Do you see *Dais* playing a role(s) in the RCH framework?
12. What do you perceive this/these role(s) to be?
13. What steps has your ministry taken to facilitate *Dais'* involvement?

Gujarat and India have placed a lot of emphasis on training Dais to ensure safe motherhood and childbirth.

14. How will the training of *Dais* be integrated into RCH?
15. Please tell me what criteria your ministry will use to select *Dais* for training?
16. What steps has your ministry taken to obtain the support of the community in the planning, implementing, and evaluating *Dai* training?
17. Identity cards:
    - What were the reasons for issuing identity cards?
    - How has this move affected/not affected *Dais'* scope of practice, knowledge and payment?
    - How will the identity cards be useful in the implementation of RCH framework?
18. Payment:
    - What criteria were used to set the rate of payment for *Dais*?
    - What were the objectives to pay *Dais*?
    - Have these objectives been achieved? If yes, how? If not, why not?

19. *Dai* Delivery Kit (DDK):
    - Please tell me some of the reasons for the giving DDK to *Dais*?
    - In your opinion, is the DDK useful to the *Dais*? If yes, how?
    - What has been the impact of issuing DDK to *Dais*?
    - Are there any plans in future to modify the DDK? If yes, how?

Please tell me what steps will your ministry take (or has taken) in regards to the following:

20. Health and other physical infrastructure (buildings, medical supplies, health facilities, staffing).
21. Social infrastructure (linkages between community and health care system) to ensure that mother and child receive appropriate and accessible care.
22. Apart from training *Dai*s, what other alternatives is your ministry exploring to ensure that obstetrical care reaches to all women in the urban and rural areas?
    - What are the potential social and economic implications of these alternatives?
    - Have any of these alternatives been implemented?
23. Do you think that *Dai*s will be around in the future? Please elaborate your answer.
24. Are there any questions that you think I should have asked but did not? Any other comments or views?

Thank you for participating in this interview.

Doctors, Nurses and Other Health Care Workers at the Primary Health Centre/Sub-Centre and SEWA Community Health Workers

1. Please tell me about yourself.
2. How long have you been working at this health centre?
3. How did you come to work in the rural area?
4. What is the population (and how many villages) that this PHC/sub-centre cover? How many patients do you see per day?
5. What type of patients do you see?
6. Who else work at this health centre?
7. Do you live on-site?
   - What are the facilities available in your living quarters?
   - Apart from you, who else lives at staff quarters?
   - What are some of the difficulties/problems that you encounter while living here? Why do you stay despite the difficulties?
   - What suggestions do you have to address some of these difficulties/problems?
8. Infrastructure and services available at the health centre
   - Please tell me the type of facilities available at this health centre.
   - Is the health centre well equipped? Are the equipment in working condition?
   - What are some of the services provided by this health centre?
   - Besides the services that you have mentioned, what other health work that you and your colleagues do?
   - Is your Primary Health Center/Community Health Centre (PHC/CHC) equipped to handle emergency cases? If yes, what kind of treatment do you provide?
   - If no, what do you do when there is an emergency? Where do you refer? How far is the referral centre from you CHC/PHC/sub-centre?
   - Does your health centre receive any emergency obstetrical/gynaecological cases?
   - What are some of the obstetrical emergencies do you encounter?
   - What do you do when an emergency obstetrical case comes to your health centre?
9. Questions regarding the health status of the villagers under the care of you health centre.
   - Please tell me what you consider to be good health? What criteria would you use to ascertain a healthy individual?
   - Based on your experience, what are some of the health problems that you see in the villages? Please tell me some of the reasons for these health concerns.
   - In addition to those factors/reasons that you have mentioned, what other causes/factors that you perceive that lead to ill-health?
   - What are some of the social, religious and cultural factors that give rise to ill-health?
   - Does the caste system create obstacles/barriers in your work? In what way does this happen? Please give me some examples.
   - How do you introduce yourself to the villagers and other health workers?
   - Do you feel that you are respected as a doctor/FHW/FHS? In what way do you see this being shown?
   - Do you like the work that you doing? (Yes/No, please elaborate). If you are presented with an opportunity that you perceive to be advantageous, will you leave? Please tell me why.

10. RCH and women's health
    - What is RCH?
    - What do you like about RCH? What aspects of RCH that you do not like?
    - What has been the impact of RCH on your work?
    - Does general public know about RCH? If they do, what is their understanding? If no, tell me how you explain RCH to them.
11. *Dai*s and health care work
    - Have you met any *Dai*s in the villages that your health centre serves?
    - How do you identify a *Dai*?
    - How do villagers describe a *Dai*?
    - Have you had an opportunity to work with *Dai*s?
    - Tell me some of your experiences (good and bad) when working with *Dais*?
    - I would like to know your views on *Dai*s' work. Please describe to me what you have seen *Dai*s do.
    - Because your work is closely linked to the lives of the villagers, I would like to know whether *Dai*s' work has any impact on your own work? If so, how?
    - Have you met any *Dai*s that in your opinion are exceptional? What sets them apart from others?
    - What kind of future do you see for *Dai*s in Gujarat? In your opinion, will they continue to be present? Please explain your answer.
    - Which group of *Dai*s will continue and which ones will not? Please tell me why.
12. Training of *Dai*s and DDK
    - Have you observed *Dai* training sessions? What are your thoughts about these sessions?
    - During your observations, describe to me *Dai*s' reactions to the information.
    - Why do you think *Dai*s require training?
    - In your opinion, what has been the impact of training on *Dai*s' work and knowledge?
    - Please tell me some of the reasons for the giving DDK to *Dai*s?
    - In your opinion, is the DDK useful to the *Dai*s? If yes, how?
    - What has been the impact of issuing DDK to *Dai*s?
    - Are there any plans in future to modify the DDK? If yes, how?
13. Identity cards:
    - What were the reasons for issuing identity cards?
    - How has this move affected/not affected *Dais'* scope of practice, knowledge and payment?
    - How is the identity card useful in the implementation of RCH framework?
14. Payment:
    - What is your opinion about *Dai*s' payment?
    - Are you aware of the criteria that were used to set the rate of payment for *Dai*s?
    - What were the objectives to pay *Dai*s?
    - Have these objectives been achieved? If yes, how? If not, why not?
15. Do you think that *Dai*s will be around in the future? Please elaborate your answer.
16. Are there any questions that you think I should have asked but did not? Any other comments or views?

Thank you for participating in this interview.

Village Development Group

1. Please tell me about yourself
2. I would like to know what health means to you. How do you define good and ill-health?
3. When someone in your community say that, " I am healthy," what do they mean? For example:
    - How does he/she know they are healthy?
    - How does he/she know they do not have good health?
4. As a member of the Village Development Group (VDG), please tell me what are some of the health concerns you have regarding:
    - Women
    - Men
    - Children (newborns, infants and school-age)
    - Adolescents
    - Elderly
5. For individuals of the above groups, what health facilities/services are available to meet their needs?
6. In your opinion, what other health services or facilities that are lacking for the above groups?
7. What are some of the challenges that you and other members of the VDG experience when trying to address the above (6) at the:
    - Village level
    - *Taluka* level
    - District level

I am interested in learning more about the health of women in your village. I would like to know:

8. What are some of the factors or issues that have adverse effect on women's health?
9. Please tell me what services or facilities that are available that target the needs of women?
10. Are the women of your village able to access them? If no, what are some of the reasons?
11. Apart from what is available at the present time, what else do you think should be available to ensure that women's health issues are addressed fully?

Since my research is about Dais, I would appreciate your answers to the following questions.

12. Who conducts deliveries in your village?
13. Are there *Dai*s in your village?
14. How do villagers identify who is a *Dai*?
15. Apart from conducting deliveries in the village, what else does a *Dai* do?
16. When there are no *Dai*s available to conduct the delivery, what do the family do? What else is available to them?
17. What is the relationship between the various health care workers and *Dai*s? What have you observed?
18. How does this relationship impact the following:
    - *Dai*s' work.
    - *Dai*s' ability to access the various health services and personnel.
19. In your opinion, what do you envisage *Dai*s' future to be? Please tell me why you think so.
20. In future if there are no *Dais*, what impact will it have on the community?
21. Are there any questions that you think I should have asked but did not? Any other comments or views?

Thank you for participating in this interview.

Members of *Dai*'s Family

1. Please tell me about yourself.
2. What do you consider a healthy individual?
3. Please tell me who was the first *Dai* in your family? How did she become a *Dai*? Why did she become a *Dai*?
4. At the present time, who among your family is working as a *Dai*?
5. How do you feel that one of your family members is a *Dai*?
6. Does she attend deliveries within the family or outside?
7. In regards to her work, please tell me:
    - What aspects of her work that you like?
    - What aspects of her work that you do not like?
    - What aspects of her work worry you?
8. Please tell me the comments that your relatives make about her work. How do you feel about their opinions or comments?
9. I would like to know some of the bad and good things that you have experienced because of family member's work as *Dai*?
10. What are the effects of *Dai*s' work on your family?
11. Would you encourage other family members to work as *Dai*s? Who do you think will carry on this work?

I am interested in the role of training provided by SEWA and/or Gujarat government on Dais' work.

12. When did the *Dai* take the training from SEWA or through Gujarat health care system? What were the reasons for taking this training? Did she like it?
13. How did her training affect your family? What was done to enable her to attend the training?
14. Please tell me what happened after the training was completed? Did anything change for you and your family? Can you describe any significant event(s) that is (are) a direct outcome of the training?
15. What else have you observed since the *Dai* took the training? I would like to know:
    - Has the training made the *Dai*'s work safer or easier? If yes, how? If no, why do you think this is the case?
    - If you noticed any increase in the clientele?
    - If you have noticed any change in her income level?
    - Whether the training affected the way villagers speak to you or the *Dai*? In what way do you think this change/no change had occurred?
    - The nature of the *Dai*'s interaction with the various health care workers.
    - The interaction between the *Dai* and local government officials. What have you observed in this regard? What have you noticed about their attitude towards you?
16. In your opinion, would a change of name have any effect on *Dai*s' status? Please tell me why you think so.
17. In government documents and other literature, *Dai*s are called "TBAs." Were you consulted regarding this change of names? If you were asked for alternative names, what other names would be appropriate?

18 I would like to know your opinion about the current payment that *Dai*s receive from the government.

19 The government in considering of phasing *Dai*s out eventually. Please tell me what you think about this move.

20 Do you think that one day, *Dais* will not be found in Gujarat? If yes, why do you think so? If no, why?
21 What do you think would be the alternatives if one day *Dais* are not around anymore?
22 In future, what role should *Dais* play if they continue to provide health services in the community?
23 Are there any questions that you think I should have asked but did not? Any other comments or views?

Thank you for participating in this interview.

*Dai*s' Clients

1. Please tell me about yourself.
2. I would like to know whom you consider a healthy pregnant woman?
3. How many children do you have?
4. Where was your last delivery? Who conducted the delivery?
5. Have you had any delivery conducted by a *Dai*? What was the reason for this?
6. (If pregnant now) – Where will you go for this delivery? Please tell me about your choice (especially if there is a change from the previous).
7. If you have decided that a *Dai* will conduct your delivery, then I would like to know the reasons for your preference.
8. What had been your experience when you had deliveries conducted by either doctors/nurses or *Dai*s or both? In your opinion was there any difference between the two groups, or was it the same?
9. During your pregnancy and delivery, were your wishes listened to and met by the practitioner?
10. Did you experience any complications during your last pregnancy? If you did, what did you do? Did you consult the practitioner who was going to conduct your delivery? What did he/she do?
11. I would like to know the type of health facilities and services that are found in your village, *taluka,* and district.
    - At these locations, are there services/facilities/staff to assists in delivery?
    - Are you able to access these services if you need them (when you needed them)?

I am interested in understanding the work of Dais. Your answers to these questions will be appreciated.

12. Are there *Dai*s in your village?
13. How do you recognise a *Dai*?
14. If the person who is looking after you is a *Dai*, is she from your own caste or village? Or is she from another village and caste?
15. Who recommended this *Dai* to you? What was the reason for this recommendation?
16. If for example, you had declined to engage this *Dai*, and sought another *Dai* to conduct your delivery, who did you choose?
17. What was (were) the ramification(s) of your decision?
18. I would like to know who you would consider a skillful *Dai*? What are the qualities and skills that you would like to see in this *Dai*?

Both the Gujarat government and SEWA have offered training to Dais. I would like to know your views on this.

19. Have you heard about SEWA? If you have, how did you come to know about it? Do you know what it does?
20. (If the client has engaged a *Dai* to conduct her delivery or in the past, a *Dai* conducted the delivery) – Do you know whether this *Dai* had taken any training? If she has, how did you come to know about this?
21. (Proceed this if answer to 20 is affirmative) -- Were you able to ascertain if she had taken training from SEWA or through the Gujarat government?

22. If the *Daibehn* was trained, then what is your opinion about her:
    - Ability to address your concerns during your prenatal, pregnancy and postnatal periods?
    - Care during the delivery
    - Interaction with other community members and health care practitioners.
23. If a *Dai* did not receive training from SEWA or through the Gujarat government, would you still engage her? Please tell me your reasons.
24. What are your thoughts about *Dais'* payment from the government?
25. In your opinion, will there come a day when there will be no more *Dais*? If you think that this will be the case, I would like to know your reasons. If you think otherwise, then please tell me why?
26. If there are no more *Dais* in Gujarat, what do you think would happen?
27. Who do you think would take their place?
28. What do you envisage *Dais'* future to be in Gujarat?
29. Are there any questions that you think I should have asked but did not? Any other comments or views?

Thank you for participating in this interview.

Chief District Health Officer (Mehsana) and Chief Medical Officer (Ahmedabad City, AMC)

1. How long have you been practising as a doctor? I am interested in your work and experiences in the health care sector.
2. When did you resume your current position?
3. How many villages/wards or what is the population that your office covers?
4. What are the health services and facilities found in the district/city?
5. Apart from the existing services and facilities, what else is needed to ensure that health care is accessible to the population?
6. What are some of the main health concerns regarding the people of your district/city? What are the factors contributing to these concerns?
7. How do you think these concerns could be addressed?
8. In your opinion, what would you consider to be the optimum level of health for the people of your district/city?

I am interested to learn some of the challenges that you and your colleagues face in regards to maternal and child health (MCH) and the move to implement RCH.

9. What is the level of maternal and child health in your district/city?
10. As a health practitioner, what are some of the concerns that you have regarding the level of MCH in your district/city?
11. What are some of the issues that you encounter when implementing MCH policies at the local level?
12. How has the above impacted the way MCH services been delivered so far?
13. The Gujarat government is moving towards introducing RCH. What is RCH? How is it different from MCH?
14. Has RCH framework been implemented in your district/city? How would the implementation of RCH affect the human and monetary resources in your district/city? Are there any provisions made to counter any unforeseen outcomes?

I would like to know about the Dais in your district/city and your views about their work.

15. Approximately how many *Dai*s are there in your district/city?
16. How do you and your colleagues identify a *Dai*?
17. How do you know whether there are new *Dai*s practicing in the district/city?
18. Please tell me some of the issues that you and your colleagues face when working with *Dais*.
19. How are these issues addressed?
20. At the present time, what percentages of births do *Dai*s conduct in your district/city? Why do you think this is the case?
21. Please describe the population that utilises the services of *Dai*s. What are the reasons for this?
22. What impact does *Dai*s' work have on the work of your health department?
23. What is your opinion about *Dai*s' role in the RCH framework?

Since I am interested in Dais' work, I would like to know more about their training, remuneration and the use of DDK.

24. Please tell me the goals and objectives for training *Dai*s?
25. How are *Dai*s selected for the training?

26. Have there been any evaluations done to assess:
    - The impact on *Dais*' work.
    - The impact on the maternal and child health in your district/city?
27. Identity cards: (Only for CDHO of Mehsana).
    - *What* were *the reasons for issuing identity cards?*
    - *How has this move affected/not affected Dais' scope of practice, knowledge and* payment*?*
    - *How will the identity cards be useful in the implementation of RCH framework?*
28. Payment:
    - What criteria were used to set the rate of payment for *Dai*s?
    - What were the objectives to pay *Dai*s?
    - Have these objectives been achieved? If yes, how? If not, why not?

    29. *Dai* Delivery Kit (DDK):
    - Please tell me some of the reasons for the giving DDK to *Dai*s?
    - In your opinion, is the DDK useful to the *Dais*? If yes, how?
    - What has been the impact of issuing DDK to *Dais*?
    - Are there any plans in future to modify the DDK? If yes, how?

30 Are there any questions that you think I should have asked but did not? Any other comments or views?

Thank you for participating in this interview.

SEWA Health Co-ordinator and Chair, Health Co-operative[190]

Please tell me about yourself.

1. What does being healthy mean to you? How do you define health?
2. What are some of the major health concerns that you have observed when working in the community with SEWA?
3. Why were these a concern to SEWA?
4. What are some of the strategies that SEWA has used to address these health concerns?
5. Which strategies have been successful and unsuccessful? Why do you think this was the case?
6. Can you tell me some of the ways that SEWA has tried to bring about increased understanding of health and ill-health to its members? In doing so, has this effort been extended to the public?
7. What are some of the difficult issues that SEWA deals (or has dealt) with in regards to women's health?
8. Besides efforts in curative health, what else does SEWA do to bring about increased awareness on health among its women members?
9. How does SEWA deal with the culture of silence?[191]
10. How does SEWA create a sensitive environment for women to be comfortable enough to even come out and say they have certain health problems/concerns?[192]
11. There have been many changes since SEWA began in 1972 and since you joined in 1984. Please tell me what these changes are? What further steps should SEWA take to ensure that health services are accessible to its members?
12. As you mentioned above, SEWA's membership is changing. There are now both older and younger members within SEWA. Do you think this is an important area to concentrate – the needs of an evolving membership?
13. Do you think that the health co-operative be able to meet the challenges as you enumerated above?
14. As you have mentioned in the past, *Dai*s are poor. What are some of SEWA's past and future initiatives to address *Dai*s' low remuneration rate?
15. Recently, a spearhead team was created. Please tell me what will its functions be? In what way will it add to the current effort to meet the health needs of SEWA members?
16. Apart from the economic factors that affect health (and this has been SEWA's main strategic tool to organise women), are there any social and religious that affect health?
17. When you first began your health work in the community, especially in the urban slums of Ahmedabad, what were some of the reactions of the members and their families?
18. Why do you think that when SEWA gives the same message as other women's or government organisations to women such as "that you are important, your health is a priority," women are more receptive. Why do you think women listen to SEWA?
19. SEWA Health Co-operative has been providing different kinds of health services. How do members and workers decide which health services or benefits would be useful to women?
20. Would some of the criteria be age, gender, income and the physical environment that women live in?

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[190] Throughout the questionnaire I refer this to SEWA for two reasons: first, to avoid verbiage; and second, all of SEWA's co-operatives follow and reflect SEWA's overall goals and objectives.

[191] This question came about from Mirai's previous answer. It was not part of the scripted questionnaire. I therefore posed the same question to the Health Coordinator.

[192] As footnote 181. Other questions that arose spontaneously as part of the answers are Q. 19, 23, 25, 26, 27, 28, and 37.

21. When did *Dais* become the focus of SEWA's organising work?
22. The findings of the 1991 study of 30 *Dais* working in a peri-urban – was it a wake-up call or did SEWA already knew the issues faced by these women?
23. What were the goals and objectives of the 1991 study? What did SEWA intended to do with the results of the study?[193]
24. Going back to the 1991 study, and the initiatives that came about from the study, what were some of the lessons learned that guided SEWA's future work with *Dais*?
25. When you mentioned trust, how did SEWA CHWs gain the trust of community members?[194]
26. But if you mainstream *Dais*, do you think that one of SEWA's objectives of respecting *Dais*' (and women's) indigenous knowledge would be lost?[195]
27. How would mainstreaming *Dais* affect their social position?
28. SEWA is embarking on a new project – the opening of a *Dai* School. When was the idea first put forward?
29. Based on the lessons learned in the 1991 study and your experience working with *Dais*, what criteria will be used to:[196]
    - Select the *Dais*
    - Design the curriculum and duration of training
    - Evaluate *Dais* after training
    - Recruit the trainers
    - Manage the school
    - Certify *Dais*
30. Would you be seeking feedback and co-operation from other NGOs in Gujarat and India?
31. Also today, I heard during the meeting that there are concerns about teaching "too much" to *Dais* such as taking of blood pressure etc. What are your views on that?[197]
32. What about offering refresher courses? Will there something like this in place to ensure that *Dais* be up to date with their knowledge?
33. What future plans does SEWA have for the *Dais* apart from *Dai* School?
34. What are some of the future plans of SEWA's Health Co-operative? Where do you see it being positioned in the next 10 or 20 years?
35. How do you see the future structure of the Health Co-operative fitting with SEWA's overall goals and objectives?
36. Where do you see yourself in five years' time?
37. Are there any questions that you think I should have asked but did not? Any other comments or views?

Thank you for participating in this interview.

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[193] Although in this question I did not ask about the identity card, Mirai explained how it came about.

[194] The issue of trust came about when Mirai explained that some community members did not trust SEWA's CHWs when they began their health work, especially when dispensing medications.

[195] SEWA believes that one of the ways that self-employed women can gain legitimacy is to be part of the mainstream economic system. In this way, women's contributions are recognised and accounted for.

[196] At the time of this interview these were not concretised; however, Mirai had some ideas on how these could be operationalised.

[197] I was present at this important meeting. All SEWA leaders, including Ms. Ela Bhatt, *Dai* leaders, potential trainers, and *Dais* were present (February 2000).